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ABSTRACT

This manual had its origins in a training project at the University of Michigan directed at the staff and directors of area planning agencies on aging. The manual is a revised version of a manuscript used in the regional workshops to facilitate the planning and coordination of services and programs for older people. Its purpose is to provide an overview of the major processes and concepts in aging, and a review of the important policies and programs affecting the nation's 21 million elderly. (Author/SJL)

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Aging

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James D. Manney, Jr.

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AGING IN AMERICAN SOCIETY

An Examination of Concepts and Issues

JAMES D. MANNEY, JR.

The Institute of Gerontology
The University of Michigan-Wayne State University

Program for Continuing Education in the Human Services
The University of Michigan School of Social Work

3 Ann Arbor, Michigan 1975

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To Sue

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PREFACE

Aging in American Society had its origins in a training project at the University of Michigan directed at one of the newer groups of professionals to enter the field of aging. This particular group consisted of staff and directors of area agencies on aging. These are regional planning units which were established throughout the nation by the 1973 Amendments to Title III of the Older Americans Act.

Area agencies are new units of local government with a unique and formidable assignment. These agencies are responsible for regional planning and coordination of services and programs for older people. Their staffs must identify new resources in the community and tap them for the benefit of the elderly. The legislation establishing area agencies directs them to develop a comprehensive and coordinated system of services for older people. The goal of this whole enterprise is to help older people function independently, as contributing, valuable members of their communities.

The men and women who staff area agencies obviously must possess a wide variety of skills. The area agency assignment calls for a tireless person who can make effective use of the tools of both public relations and technical planning, who can negotiate the labyrinth of government at all levels, who can administer an office, organize a community, find new funds, and speak plausibly to both old and young, to the powerless and the powerful.

Several years before the area agency legislation actually became law, the Administration on Aging took steps to provide these individuals with useful training experiences. It funded a project at the University of Michigan to develop training materials. Later, the AoA asked Michigan, Syracuse University, and the University of Southern California to conduct a series of workshops for area agency staff. These workshops, which were held in the Spring of 1974, relied heavily on the Michigan materials.

Aging in American Society is a much-revised version of a manuscript used in these workshops. Its purpose is to provide a succinct overview of the major concepts in aging and a review of the important policies and programs directed at the nation's 21 million elderly. The other material produced by the Michigan Project TAP (Training Area Planners) had similar purposes.

Several individuals encouraged me to revise this training document and to develop this book. Chief among them is Wayne Vasey, co-director of the Institute of Gerontology during the time of this project, and a generous source of personal and professional inspiration. His mark is on this book.

especially in the analysis of the economics of aging in Chapter 10. William Lawrence and Armand Lauffer, co-directors of Project TAP, gave abundantly of their time and enthusiasm.

Clark Tibbitts, Marian Miller and Olivia Coulter of the Administration on Aging were consistent sources of support. Dr. Tibbitts, a renowned gerontologist and government administrator, offered suggestions on the organization of the book. He and Ms. Miller supplied dozens of helpful suggestions and revisions in the text.

Others who reviewed and commented on the manuscript include Willis Atwell of the AoA and Hiram Friedsam of North Texas State University. Several other scholars and governmental experts in aging reviewed the manuscript for the AoA but, unfortunately, their identity is unknown to me. To all these men and women, my grateful thanks.

Grateful thanks as well to my colleagues at the Institute of Gerontology and my co-workers on Project TAP from the Program for Continuing Education in the Human Services at the University of Michigan School of Social Work. Robert Huber and Woodrow Hunter provided material which was incorporated into the text. Michele Christner and Gail Scho put the resources of the Institute's library at my disposal. In addition, Ms. Christner prepared the appendix to this book. Robert Benedict, now Pennsylvania Commissioner on Aging and a former colleague, provided the basis for the life cycle perspective on pages 14-15. Marcia Cameron coupled diligent typing and proofreading with valuable suggestions for revision and reorganization. Those who typed and proofread successive versions of this manuscript, always under conditions of direst urgency, include Carla Barnes, Rachel Driggs, Irene Flynn, Pat Hanford, Jim Irwin, and William Mahder. My gratitude for their diligence and good humor.

A special word of thanks to Eloise Snyder, my colleague in the Institute of Gerontology Publications Office. She applied her editorial skill and wide knowledge of the field of aging to this manuscript at many crucial points.

Joe Hemingway of the Mississippi Council on Aging, and John L. Maxey and David Michaels of Community Legal Services of Mississippi in Jackson are largely responsible for the idea of writing a new chapter on the Law and the Older Person.

Bill Howison of the University of Michigan Publications Office designed the cover and his colleague John Hamilton expedited the composition and printing. Neal and Ned Collins of CompType handled the composition and Jim Holefka of Lithocrafters coordinated the printing and binding. I have never worked with a more generous and capable group of professionals.

In this book, I essentially select and interpret the work of other people. While I have had much invaluable help in this task, I take full responsibility for its limitations.

James D. Manney, Jr.

Ann Arbor
November, 1974

PART I

THE PROCESSES OF AGING

CHAPTER 1

A PERSPECTIVE ON AGING

> There are positive roles for aging people, through which they can make valuable contributions to society. This point of view calls for a new concept of aging—a concept that gives recognition to the positive as well as the negative aspects of maturity.
>
> —Clark Tibbitts

Our attitudes about aging are important. When we meet an unfamiliar old person on the street, in an office, or at a meeting, we smile or frown or present a neutral mask, depending on how we feel about aging and the elderly. The professional's view of aging heavily influences his goals as he interacts with older people. Should the counselor try to help the old person become reconciled to a grim situation, or should he try to open new possibilities and potentials in the later stage of life? Is the social worker scrambling for resources to forestall a catastrophe, or is he helping the older person live in a way that is satisfying to him and others? Our view of aging affects our decisions as voters and citizens about better health care, Social Security, housing, recreation, transportation—the many social programs and institutions that older people have come to depend on. Ultimately, our perspective on aging largely controls the course of our own aging. We are subject to the well-known sociological observation that we tend to behave in ways consistent with our own expectations of ourselves.

For all these reasons, we should deliberately adopt the most positive concept of aging that can be entertained without doing violence to what science tells us about the aging process. In this book, we shall deliberately stress this hopeful view. We do so partly as a simple corrective to the prevailing negative view of aging and older people. As Tibbitts points out in the remarks that begin this chapter, positive contributions by aging people largely depend on a new concept of aging, one which gives equal weight to the positive as well as the negative aspects of maturity. After all, the negative aspects of later life are quite well known. We must *choose* to look at the potential of old age along with its liabilities. Such a choice also has practical consequences. A hopeful and positive perspective on aging would tend to direct our choices as citizens, professionals, and social beings in a positive direction—at least as far as the elderly are concerned.

As desirable as a hopeful view may be, it requires evidence. Biologists have rather carefully measured the physiological changes that occur with age, and the data, on the whole, is not favorable. With age, physiological systems deteriorate and eventually make the organism vulnerable to an ultimately fatal illness, infection, or accident. On the cellular level, the genetic code of DNA appears to include a self-destruct program. Cells are "switched off" at a predetermined time. The life span of all organisms, including humans, appears to be governed by a biological clock.

The years we live as this clock is running down are known as old age or the later years. The actual behavior of old people, as casually observed by almost everyone and measured by psychologists and sociologists, does not appear to justify a clear case for a positive view of aging. Old people are slow. The very old tend to be very slow, in thought, word, and deed. They comprehend instructions, requests, and ideas more slowly than young people, and take a longer time to act in response to things seen and heard. Older people also seem to *do* less with their time and to be less active within a given unit of time. The range of their activities is likely to shrink; many old people have made a heavy and fussy investment in the little routines of daily life. Placed in competition with a younger person in a time-limited learning situation, the elder will probably finish last. He is likely to have trouble keeping several things in mind at once, to display a faulty memory, and to be rattled by a tight time limit.

Furthermore, the very old person seems to have a less intense relationship with his physical and social environment. He may be quite obviously passive and dependent, expressing his condition by sullen apathy or whining demandingness. The elder has fewer close personal relationships, and takes longer to form new ones. He is likely to have appropriated a number of negative ideas about himself and his condition which add up to the notion that he is less valuable as a human being because he is old. Perhaps as a result, many oldsters give the impression of being adrift, of not having any real reason to do one thing rather than another—or to do anything at all.

How do we explain this behavior? It appears to be clear evidence of a psychological and behavioral decline caused by or running parallel to bodily deterioration. It seems to confirm what most younger people feel: aging is bad and old age is a murky misery. The biological evidence is clear enough. No matter how positive we might want to be, probably no one would willingly choose to live in an old body. But are we justified in leaping to the conclusion that bodily deterioration causes deterioration in thought, or that the process of aging brings increasingly inappropriate patterns of behavior?

The evidence does not support such conclusions. In general, gerontologists have been much more successful in describing the characteristics of old people than they have in properly attributing some of these characteristics to socio-cultural influences, and others to a hypothetical universal process of "aging." The methodology of gerontological research contains flaws, and scientists have been unable to sort out the causes of what they observe. Thus, we have no reason to believe that the darkest view of aging is the correct one.

The psychologist Robert Kastenbaum illustrates the problem with an amusing anecdote about a researcher studying a Boston neighborhood. The old residents often spoke English with an Italian accent, while their children and grandchildren did not. After much thought and field work, the investigator reached the following conclusion: "As people grow older they develop Italian accents. This surely must be one of the prime manifestations of aging on the psychological level." Kastenbaum's point, of course, is that we can never describe the characteristics of people who happen to be old at any given time and simply assume that we have also described the processes of aging. Is there such a thing as a fixed portrait of the older generation? From a logical standpoint, probably not. Today's older generation has been substantially disadvantaged in terms of education, financial security, recreation, mobility, and other opportunities commonly enjoyed by their children and grandchildren. The older generations of the future are likely to behave quite differently from that of the present.

In more scientific language, we can say that the negative behavioral characteristics of many older people can be attributed to psycho-social influences as well as to a hypothetical and unproven link between biological and psychological deterioration. For example, developmental psychologists have found that our perception of the social environment changes with age. Forty-year-olds think their world rewards boldness and aggression, while sixty-year-olds perceive their environment as complex and dangerous. Caution, slowness, and a more passive stance would follow logically from such a perspective. The same behavior can be explained as a response to the numerous physical and social losses older people typically suffer—loss of spouse, friends, health, home, occupation. Indeed, young people who suffer severe loss frequently act like old people. They tend to be cautious about forming new relationships, preoccupied with bodily functions, estranged from the flow of daily life, and sometimes badly depressed. Kastenbaum suggests that the "bereavement overload" inflicted on many old people can by itself explain much of their behavior. If such psycho-social components are involved in the negative behavior of old people, there is no reason why psycho-social intervention cannot turn their behavior in other directions.

Perhaps the characteristic of older people which the young dislike the most is the impression of aimlessness which old age seems to radiate. Throughout birth, growth, education, reproduction, and active work, life seems to have a purpose. But beyond middle age, the script seems to run out. The later years appear to be a time of increased ossification of the mind and body. A dispassionate biologist might claim that the aimlessness of the later years is the price man pays for daring to live beyond the time of his primary evolutionary function of reproducing the species. But may we suggest that the running out of the script makes the later years the most open and malleable time of life, at least potentially.

Surely there are some older people who seem to exploit this potential to the fullest and continue to flourish until they die. Every field of human endeavor, from politics to religion, from science to art, has been enriched by memorably creative contributions by individuals in their seventh, eighth, and ninth decades of life. How can we explain these people, except by agreeing that they have discovered ways to counteract processes which we perhaps too readily accept as universal and inevitable phenomena? There is some evidence now that continued psychological growth into advanced old age is a possibility for most people, not just for the exceptional genius. Until recent years, most psychologists thought that intellectual performance reached its peak in early adulthood, remained stable for about 20 years, and then steadily declined. Now, long-term studies of intellectual ability are beginning to show that most types of mental performance improve or remain stable until the time just before death.

These studies provide empirical evidence for a new positive concept of aging. Since the studies show that mental performance has improved among hundreds of people who have already grown old, we may reasonably claim that a productive and fulfilling old age lies within the grasp of the current older generation, not just the generations that will grow old in the future.

This chapter builds the case for a positive, developmental perspective on aging. Most people in America view aging in a negative fashion. It is this collection of adverse attitudes, myths, stereotypes, and prejudices that lies at the heart of the distress and difficulty of many older people, and hinders the continued development that could be theirs.

I

VIEWS OF AGING

The American View of Aging

The American attitudes towards older people emerge forcefully in our language. We scorn them ("old coot," "old fool"); find them rigid and useless ("you can't teach an old dog new tricks"); think they are silly ("old biddy"); and, in a revealing phrase, perceive in them a sexual threat ("dirty old man"). At the same time, language also reveals the euphemistic attitudes which cover the underlying hostility ("golden years," "senior citizens"). Other myths and stereotypes abound. We believe that old people are serene; that their children usually abandon them; that they become more conservative; that they cannot learn or accept anything new; that sexual expression is not important after a certain age; that older people's behavior can be attributed to senility as the brain degenerates. None of these stereotypes is accurate, yet this childlike portrait influences the way the young behave toward the old. We humor old people, visit them dutifully, care for them if necessary, and keep them out of sight.

Such myths and stereotypes flourish because older people are not very visible in our society. Many of us can live most of our lives without ever knowing any older people except our own grandparents. One American in ten is over age 65 today, but these 21 million people are largely invisible in our homes, offices, stores, streets, schools, airports, restaurants, and theaters. When they do appear, a curious thing happens: we don't see them. The French novelist Benoîte Groult captures this custom well when she describes a young woman accidentally coming face-to-face with an old man on a bus. The woman turns her eyes away "to avoid catching the disease."

The American author Sharon Curtin noticed something similar in rigidly enforced age segregation between old and young within a small park near a nursing home. The old people sat on one side; young mothers supervised their children's play on the other. Whenever a child ran over to the old people's side of the park, a mother would follow anxiously, hustle the child away, and murmur an apology to the oldsters. She comments:

> Now, it seemed to me that the children didn't feel any particular fear, and the old people didn't seem to be threatened by the children. The division of space was drawn by the mothers. And the mothers never looked at the old people who lined the other side of the park like so many pigeons perched on the benches. These well-dressed young matrons had a way of *sliding* their eyes over, around, through, the old people; they never looked at them directly. The old people might as well have been invisible; they had no reality for the youngsters, who were not permitted to speak to them, and they offended the aesthetic eye of the mothers.

Myths and stereotypes about old age flow from our casual but strict habit of expecting people to act in certain ways simply because they have reached a specified chronological age. Again, this tradition emerges in our language. We all know children who act "old for their age," retired people who "act young," adolescents who "won't grow up," and sober family men who suddenly enter their "second childhood."

Expectations based on chronological age are pervasive, and often quite detailed. Our first question upon hearing that the local school board has named a new superintendent is: how *old* is he? Upon receiving the answer, the expectations fall into place almost automatically. If the new administrator is over 50 or so, the appointment is "safe." The new man won't "shake things up" and bring in "new blood." The newly-named superintendent may even greet the stereotype warmly by promising to "consolidate the school system's gains of recent years." However, the school board has made a "daring appointment" if it chooses someone in his forties or thirties. The new administrator will "change things" and probably "won't be around very long." Many will be surprised if the older man gets innovative (disruptive) or if the young man turns cautious (prudent).

This pattern of thought and expectation permeates our lives. How *old* is my boss, my mayor, my spouse, the TV performer, the people I shall meet with tomorrow? How old am I? We want to know the answer in terms of a quite specific number of years. It makes a subtle difference in response and expectation if one's boss is 46 or 55, if one's spouse is 29 or 37. Even if the chronological age can make no conceivable difference, we simply need to know it. In a newspaper or magazine profile of a public personality, the individual's exact chronological age is usually among the first facts offered. To establish people in our minds, we must know their age.

Such age-stereotyping is destructive for older people because it allows our casual attitudes toward age to merge with our more formal conceptions of age. Beneath all the euphemisms and unscientific prejudices, Americans view aging as an irreversible biological process which systematically degrades the individual. The very word "aging" conjures up physical and biological images: gray hair, wrinkles, weakness, fatigue, bent spine, shuffling walk, sickness, pain, physical dependency. At the end of aging is death, our universal fate.

Our culture's conception of aging as a primarily biological process leads to other characteristic views. Since we think the dynamics of aging lie in the natural laws of life, we attribute the generally stagnant mental and social life of the aging person to physical changes with age. Thus, we assume that retirement is proper because older people become incapable of doing their jobs. We believe that forgetfulness, momentary confusion, and slowness of action are caused by senility—a biological condition. Young people may try to cheer up a depressed older person, but the underlying attitude is probably something like, "I'll probably be depressed too when I'm that old." In focusing on the physical decline, we dismiss the possibility for the older person's spiritual, mental, emotional, and social growth. Too often, the old person dismisses this possibility as well.

Gerontologists, the scientific students of aging, sometimes introduce these negative connotations into their definitions of their subject matter. Observing that the human body is at its most vigorous at the age of 12, one gerontologist suggests that:

> Later we shall undergo a progressive loss of our vigor and resistance which, though imperceptible at first, will finally become so steep that we can live no longer. . . This decline in vigor with the passing of time is called aging.

If we applied this dour definition of aging to real life, we would have to conclude that humans pass their prime at age 12. Other gerontologists define aging more flexibly. They view aging as a developmental process, beginning with birth and ending with death. Throughout life, the individual undergoes gains in some functions and losses in others. At each stage, some options close and new possibilities open.

Yet the negative biological view of aging persists—in academia, in our culture, in our popular beliefs and attitudes. It is probably so durable because Western culture is the first in history to enforce a social segregation between young and old. Old people are burdened both with age and with social isolation. We believe that the social downfall of the aged is caused by their physical decline. We are reluctant to entertain the contrary hypothesis: that by rejecting the old, we precipitate and aggravate physical aging. This leads to a sobering question: do our social arrangements for old people turn aging into the deteriorating process we consider it to be?

Other Views of Aging

History, anthropology, and art strongly suggest that our culture, which makes creative aging an exception, is itself an exception in mankind. The Western notion that aging is primarily an irreversible biological process which leads to negative mental and social consequences is a relatively new idea in history. Other cultures have regarded aging as a spiritual as well as a biological process. It could lead to either growth or decline, depending on the individual's dedication, resources, inner strength, and luck. Aging could bolster a person's spiritual strength by giving him insight, knowledge, and freedom. In short, other cultures and even our ancestors tended to see aging as a time of possible spiritual growth until death, as a differential and somehow manageable process.

One caution: we must not romanticize the status of old people in Eastern, preliterate, and historical societies. Old people in these societies often enjoyed higher status, but it is unlikely that many elderly Americans of today would choose to trade places with them. Life was hard and death came swiftly to old and young alike. Far fewer people lived to an advanced old age than do today. Those who did survive had to struggle against severe economic hardship. Furthermore, in all times and places, the young have inflicted terrible cruelties on the old. The difference is one of perspective. We see the devaluation of old age as a law of nature. Most other societies have seen the circumstances of their old people as a feature of their culture.

For a different view of aging, consider the words of the Chinese philosopher, Confucius, speaking to his followers about aging:

> At fifteen my mind was bent on learning. At thirty, I stood firm. At forty, I was free from delusions. At fifty, I understood the laws of Providence. At sixty, my ears were attentive to the truth. At seventy, I could follow the promptings of my heart without overstepping the mean.

This characterization of aging as a process of growing wisdom strikes a responsive chord in the American consciousness. Yes, we say, the old must be wiser. They have seen more, done more, achieved the detachment from passions, pretensions, and ambitions which is necessary for wisdom. Yet older Americans who command this respect from their society are notably rare. The predominant notion is that old people are obsolete, not wise, and that the wisdom they possess is useless in a rapidly changing, bewilderingly fluid culture.

We find quite another view of aging in a story about the African Akamba tribe, recounted by Leo Simmons. The elders of the tribe gave a reception in honor of a younger man who had just returned from a trip around the world. After listening to the young man's account of his travels, the chief thanked him saying, "You have seen much. You are old, and we are but children. You have made us older than we were. But you are older still, for you have seen with your eyes what we have only heard with our ears." To the Akamba, aging does not depend on the amount of time elapsed since birth, but on the ripening of knowledge acquired, and on the extent of personal experience. Aging appears as an enviable growth in learning, not a process of physical decline. Furthermore, aging appears as a differential process: the young man has matured more quickly than his elders because he was exceptionally favored. Aging can thus be controlled.

Michel Philibert, a French gerontologist and philosopher, sums up the Western perspective on aging in four main points: (1) aging is a biological rather than a spiritual, social, and cultural process; (2) aging is unfavorable; (3) aging is universal and eternal rather than differential and variable; and (4) aging is unmanageable. We shall now briefly discuss these points.

1. *Aging is a biological rather than spiritual, social, and cultural process.* The biological conception of aging governs our perspective, even though biological decline is only one of the changes that we undergo. Our mental images of age are primarily images of unfavorable physical change. We explain psychological and social changes in terms of this biological stereotype. A problematic social institution such as retirement becomes a necessary response to biological decline. Social isolation of the elderly becomes an appropriate, if regrettable, arrangement for people whose physical conditions are rendering them socially and economically obsolete. The biological conception of aging even governs much of academic gerontology, which itself developed from the biological sciences. However, the Western view is a minority view. Historical, non-Western, and primitive cultures tend to view aging as a process in which physiological, spiritual, and cultural forces have at least equal weight. They do not necessarily consider growth in learning, continuing maturity, and creative accomplishment in later life as unusual.

2. *Aging is unfavorable.* The Westerner's biological model of aging must be pessimistic; the dominant physical experience in later life is one of loss and decline. It largely shuts off the possibilities for growth and fulfill-

ment in old age, possibilities which other cultures expect. The underlying conception is fundamentally different. All major cultures in history as well as our own have recorded examples of contempt for the old. However, past societies have tended to view this contempt as a feature of its own culture, usually one which that culture itself perceives as aberrant and inhumane. Our society views the devaluation of the old as a law of nature and considers the creative elder the exception.

3. *Aging is universal and eternal rather than differential and variable.* If aging is a phenomenon governed by irreversible biological processes, it must happen the same way in all times and places. Furthermore, such a universal process must tend to make aging people more alike. For example, if all people over, say, age 70 are undergoing a common experience of memory loss, mental rigidity, and physical decline, we can expect them to become more similar to each other as the years pass. These views are myths. Aging is a differential process which affects individuals at different rates. Also, aging has precisely the opposite effect as the popular belief. We actually become more un-alike as we grow older. The older segment of the American population displays a greater variety in personality traits, abilities, disabilities, interests, experiences, and social circumstances than any other population group. The idea that older people tend to resemble each other is partly sustained by the physical and social isolation of the elderly from the mainstream of our culture.

4. *Aging is unmanageable, not manageable.* Ironically, Americans conceive of aging as essentially an unmanageable physiological process precisely when medical science has brought physiological and biological aging under a large degree of control. We isolate and worry about older people at a time when the number of older people is increasing and they are much more healthy, alert, and capable than older people have been at any other time in history. Yet our conception of aging includes the notion that there is basically nothing we can do about it.

This conception of aging exerts a powerful influence on the way we view older people, and, by extension, on the way we ourselves will age. Ironically, we think about old people pessimistically and view aging as a universal, unmanageable, unfavorable biological process when nearly all of us can describe at least one outstanding exception to the rule. Bring up the subject of aging in a conversation with others. Someone will soon talk like this: "Yes, aging is depressing; our treatment of older people is terrible; and it's becoming a serious social problem. But you should see my Aunt Lily . . ." Aunt Lily, of course, is the ubiquitous relative, friend, colleague, or neighbor whom all of us have known. She (or he) seems immune to all the disasters and depredations of age. She's 86 and acts like she's 50. She walks two miles a day, throws parties for her younger friends, takes a flyer in the stock market, and hands out astonishingly good advice. She is the old person we would all like to become, even as we stare morosely at ourselves in the mirror, realizing that our smooth and responsive bodies are gradually aging, wrinkling, failing.

Some Key Concepts of Aging

Biological and social science research have shown that our culture's conception is false. Aging is not the simple matter that our society usually perceives it to be, but is a complex and still little-understood product of interrelated biological, psychological, and cultural forces. At least three key ideas stand out, and they will recur often throughout the rest of this book.

1. *Aging is varied. It has no chronological rules.* The forces of aging affect individuals and groups of individuals differently. The idea of the "elderly" or "older people" is a demographic notion. All of us are growing old in our unique way at our unique rate. As we grow old, we become more unlike everyone else. No matter how we choose to look at the process, aging varies tremendously in its onset and course. Different individuals vary widely in the time that physiological functions begin to decline. Within each person, different functions decline at different rates; some even seem to improve with age. The same variation is found in all psychological functions. And, of course, each individual has his own life-situation with its unique resources and deficits. One gerontologist put it well when she said that aging "is not a simple slope which everyone slides down at the same speed. It is a flight of irregular stairs, down which some journey more quickly than others."

2. *The processes of aging are interrelated.* We should be keenly aware of the interplay among the facets of aging. Society's attitudes toward older people and the roles it assigns to them affect intellectual performance, motivation, and interest in learning. A mandatory social requirement such as retirement typically cuts the older person's income in half. This in turn, affects his ability to obtain medical care, to eat well, to visit his family and friends, and to live in a house he likes. Loss of energy and strength can cause a social withdrawal. Sensory decline and a weakened ability to organize thoughts can cause accidents and lead to behavior marked by extreme caution.

To illustrate these interrelationships, consider the situation of a frail but basically healthy elderly widow who is resting unhappily in a local nursing home. Federal, state, and local budget officials may want her out of the nursing home because they have concluded that her condition is not serious enough to justify the heavy expenditure of public money on the round-the-clock nursing care she is receiving. The woman and her family may agree; she wants to go home because she is unhappy and is not really sick. But the woman is probably a patient in the home for complex reasons. She is not able to live independently because the processes of biological aging have made her weak. She may be unable to exploit the physical resources she has left because widowhood, poverty, sickness, and other crises have taken a psychological toll. (She may also be developing emotional disturbances as she languishes in the nursing home.) The woman's family may be unable to help her because they do not understand her condition and have no resources of time and money to keep her in her own home.

Thus, the woman's problem—and society's—is biomedical, psychological, and cultural. Anyone who helps her must manipulate social institutions and unravel a complex web of forces and circumstances which have combined to put the woman in a place where she doesn't belong.

3. *Aging is a developmental process.* Just as one process of aging cannot be understood in isolation from the others, old age itself cannot be understood in isolation from middle age, adulthood, youth, adolescence, childhood, and infancy. Life is continuous: the old man is the young man grown old. At each stage, life brings gains as well as losses, potential and actual.

II
THE LIFE CYCLE

The notions that aging proceeds irregularly, gradually, and within the framework of the individual's past life flow from a consideration of aging as something that occurs within the life cycle. The individual ordinarily passes through the phases of childhood, adolescence, adulthood, middle age, later maturity, and old age. We customarily attach approximate chronological years to mark these phases, but the chronological age only gives a clue to the phase the individual is passing through. Each phase has its own problems and opportunities, created by biological, psychological, and social forces.

This life cycle perspective on aging is important for two reasons, one rather obvious, the other more subtle. The obvious reason is that the conceptual separation of old age from past life, and the social segregation of older people, are outstanding conceptual and social errors. The strengths and weaknesses older people possess do not arise spontaneously at age 65, and older people do not possess the same characteristics from age 65 until death. Life is a continuum which constantly changes. No stage in life, no age-category, can be adequately understood apart from the others.

The more subtle point is an extension of this idea. If we can understand the old man by studying his youth, we can also understand the young man by studying his anticipation of one day becoming old. Man does not live only as a plant or animal does, in an orderly one-way progression from one stage to the next. Man anticipates events to come and decides his next step with a distant end in mind. Again, the French novelist Benoîte Groult captures this idea in a phrase: "Youth comes to an end, and behaves aggressively because it is struggling against the image of old age . . ." Thus, the life cycle proceeds in two directions. Later events are explained by antecedent events; antecedent events may also be explained by anticipated later events.

In this perspective, our society's largely negative images of old age suddenly take on new importance, not just for old people, but for all the younger people who are aging in the face of these images. Negative images are not likely to encourage us to plan intelligently while young, so we may enjoy old age's unique positive qualities. Rather, we are more likely to grow old in a way that fulfills our pessimistic expectations.

Phases of Later Life

The three phases of advanced adulthood of special interest to us here are *middle age, later maturity*, and *old age*. By viewing later life in a broad perspective, we can see that "old age" is not something that happens during the seventh or eighth decade of life, but, in fact, reaches its real turning point much sooner.

This turning point lies in the period called *middle age*. Bodily changes, which have been occurring for many years, gradually become apparent. The individual notices he has less energy, tires more easily, and needs a longer time to recover after strenuous activity. Vision and hearing loss may become noticeable. In a group of middle-aged people, chronic diseases such as high blood pressure, diabetes, and heart trouble, appear more frequently and curtail activity. The middle-aged person realizes that he cannot depend on his body as he once could. He grasps the fact that life is finite and death is real. "One day, my son beat me at tennis," a man says. "I was shocked." Says another, "a friend of mine—my age—had a sudden heart attack. That was the difference. I felt old."

Middle age can be frustrating for both men and women. The man's work career typically reaches a plateau and stabilizes; he realizes that if he has not achieved his youthful ambitions, he probably never will. The woman passes through menopause and her children leave the home for work, marriage, and an independent life. She may find herself sitting around the house all day with nothing to do. She may look for work, and find that no one will hire her because she is "too old."

However, the crises of middle age can lead to new satisfactions if they are handled well. It is a time of stock-taking, of sober awareness of one's limitations, insights which a resourceful person can use to great advantage. A man can start a new career, the departure of children can free a woman for work, a marriage can be infused with new life. In an interview, one 56-year-old government administrator made a remark which reflected the complexity of middle age: "Time is now a two-edge sword. To some of my friends, it acts as a prod; to others, a brake. It adds a certain anxiety, but I must also say it adds a certain zest in seeing how much pleasure can still be obtained, how many good years one can still arrange, how many new activities can be undertaken."

Later maturity, the phase of the life cycle which follows middle age, is marked by changes in both the individual's social circumstances and by bodily decline. During this period, the person is retired from work, his income usually drops by about half, and the pattern of his familial and other social relationships is altered drastically. During this time, one-half of the women are widowed and one-fourth of the men become widowers. The drop in income which comes with retirement usually restricts the individual's options. He may not be able to travel where he wants, eat the right kind of food, see a doctor as often as he should, or move to more appropriate housing. Most people have mixed feelings about retirement: relief at the prospect of release from workaday drudgery; anxiety about what to do with leisure time; and resentment at being judged unable to fulfill a productive role.

Chronic health problems begin to limit activity during later maturity. Sensory and some mental functions continue to decline. Reaction time slows, the eyes pick up less detail, the person has a hard time immediately recalling facts and names. As these gradual, annoying changes rise to the surface of the individual's consciousness, he enters what psychologists call "the crisis of the first awareness of aging." He realizes he is declining, and that his problems today herald worse problems tomorrow.

While many people never manage to overcome this crisis, and go on to experience later maturity as a time of decline, others find that this phase includes unique satisfactions. Complete freedom from parental responsibility and work can open more choices than at any previous stage of life. Many maintain their health and psychological capacities and draw on a lifetime of interests, friendships, and activities which they have found appealing. Many individuals find later maturity the most satisfying period of their lives.

Middle age and later maturity are phases of the life cycle in which the influence of modern industrial civilization is most apparent. Although physiological changes occur during this time, it is only in this century that social forces and institutions such as retirement, mobility, and urbanization, technological change, and medical expertise have made middle age and later maturity into separate phases of life. Pre-industrial man knew only two phases after childhood—adulthood and old age. He took his place in the social and economic life of the farm, village, or small town and worked until he died of infectious disease, or until the accumulated deficits of old age incapacitated him.

For modern as well as primitive man, the final period of *old age* is characterized by dependency. If a person lives long enough, the decline of his physical and mental capabilities may eventually render him incapable of managing himself. The people who need the most specialized and extensive array of services, including institutional care, tend to be those who live into old age. As old people face dependency and frustration, they confront a second psychological crisis—"the crisis of awareness of massive age change." Some react with passive resignation, angry aggression, regression, or with compulsive and fixated activity. Some withdraw into themselves and prepare for death by reconciling past conflicts and finding ultimate meaning in their lives.

This life cycle summary of the processes of aging is studded with large generalizations. It is an attempt to give perspective to a series of processes which affect individuals in different ways and elicit different responses from them. For example, retirement is not a simple, universal process which evokes neatly predictable responses from workers. Some greet retirement with joy while others are shattered by the prospect of empty days. Even the very elderly experience very diverse personal and social circumstances. Some of the estimated 7,000 centenarians in the United States are vigorous, healthy, and alert. Others are totally incapacitated. Social service personnel are ordinarily concerned with the neediest, most vulnerable older people. They should remember that at any one time, most older people are relatively healthy, in full possession of their faculties, and able to manage for themselves.

The Life Cycle Perspective

The life cycle perspective on aging can help us sort out the astonishing variety of needs of older Americans. A middle-aged woman looking for work and a frail old man being transferred from a hospital to a nursing home have very different problems and need very different services. We can better understand the nature of these needs by considering what happens as older people proceed through the life cycle. A life cycle view of older people's needs would look like this:

50-65	**65-75**	**75-85**	**85-death**
Departure of children from home, career stabilization, nagging health problems.	Retirement, income problems, widowhood, chronic health problems, death of friends.	Further loss of health, friends, strength; threat to independence.	Serious loss of health, critical income need, dependency.

Role Reorientation______________________________

Social Intervention____________________

Personal Intervention__________

Personal Maintenance____

This continuum appears to be a continuum of loss, beginning in middle age and continuing to advanced old age and death. This display of loss and decline does not mean that we must view aging in the stereotypical way—as a depressing and unfavorable process. On the contrary, the system of social services should be arranged so that society intervenes in older people's lives in an *appropriate* way, precisely so that older people can compensate for their losses and fulfill the possibilities available to them.

The lines across the bottom of the chart suggest the types of services most appropriate at various stages of the life cycle. Those passing through middle age need to reorient their lives. Services suitable for these individuals include recreation, educational opportunities, employment counseling and job training, volunteer work, preretirement assistance, and preventive medical care. As noted, this role reorientation effort can continue throughout old age, although other services take priority in importance as the individual ages.

Role reorientation continues after retirement, but the older person now requires new help to compensate for his dwindling social and economic resources. The programs and services which emerge now include Social Security and other income maintenance programs, Medicare and Medicaid to pay medical bills, special transportation help, and perhaps programs related to housing needs. Later, as health fails in the seventh and eighth decades of life, services designed to maximize the older person's personal independence take priority. These include home health aide or homemaker services, and arrangements for personal care. Finally, personal maintenance is frequently needed at the end of life. The aged person becomes completely dependent on others for the management of his life, and often requires institutional care.

III

THEORIES OF AGING

The theoretician who proposes a conceptual scheme to explain the process of aging faces a formidable task. He must explain loss—the decline of bodily functions and the shrinking of the aging person's social options—as well as potential gain. Many vigorous and productive elders show that this potential can be exploited. The theoretician must also contend with overwhelming diversity. Aging differentiates personal characteristics, and older people exhibit the widest variety of personal characteristics imaginable. Not surprisingly, theoreticians have found it harder to explain the process of change in later life than changes in earlier years. Only one of the systematic views of aging—disengagement theory—can be called a "theory" in the scientific sense of the term. One other—developmental theory—is a still-tentative effort to apply theories of earlier years to the latter phase of life. The other "theories" we shall mention are more properly called conceptual schemes. They are ways of looking at aging which yield insights, and are helpful ways of viewing processes and potentials which are little understood.

The Study of Aging

The theoretician's difficulties are apparent in the difficulties social scientists have encountered in the systematic study of aging. It is important to understand these problems, and to bear in mind the limitations they impose. As a discipline, social gerontology is in its infancy. Not only are different theories offered to explain the same data, but the data itself is frequently contradictory. Very little is known about such crucial topics as the retirement process, minority group elderly, and older people's use of community transportation systems. The answer to one very important question--why some people are devastated by old age while others flourish—are still very much hidden. Impressionistic observations are important components in the study of aging; they are often more important than "objective" observations made in the structured setting of a research project. Finally, elements of social criticism are seemingly inescapable in the study of aging. Many gerontologists are deeply concerned with attacking popular myths about older people, evaluating the extent and effectiveness of services for the elderly, and advocating their case in society. Many scientists say such concerns are inappropriate in an "objective" search for "truth." Others reply that objectivity and truth are relative concepts, that the social scientist who claims to be purely "objective" is merely deluding himself. Nevertheless, impressionistic observations and social criticism muddy the theoretical waters.

Variety. Perhaps the first problem in the study of aging is the vast heterogeneity of older people. While we use the term "older person" as if it described a single homogeneous category, the older population is actually more varied than any other. America's older people are as different as race, religion, social class, education, and occupation can make any group. They are further differentiated by lifetimes of individual choices to live a certain way, adopt certain interests, and cultivate certain skills. Nevertheless, older people have certain common experiences simply because they have grown old in American society. The challenge to the gerontologist is to determine what their common problems and experiences are without losing sight of individual uniqueness.

Sampling. Another research problem which plagues gerontologists is finding an adequate sample of older people in order to make accurate studies of their characteristics, needs, experiences, and changes over the years. The Social Security Administration, the Internal Revenue Service, and the Census Bureau are restrained by law from releasing lists of names. Most other available lists are much less inclusive. For example, we know little about retirement because only specialized lists of retirees from individual companies and labor unions are available. Generalizations based on studies of such specialized groups of older people are always tentative.

Cross-section studies. Many conclusions about aging are based on cross-section comparisons of various age groups at one point in time. Today's older people are compared to today's younger people and the differences are dubiously attributed to the effect of aging. While this is the easiest way to conduct certain kinds of social research, few, if any, age-related differences in the population can be simply attributed to aging. Clearly, forces other than aging are also at work. A man who is 70 years old today is likely to be an immigrant or the child of immigrants, to have finished his formal education in the eighth grade, to have grown up in an agricultural and small business economy, and to have lived through the dislocation of two wars and the Depression. His attitudes, experiences, characteristics, and needs will be different from those of a 25-year-old who grew up in the postwar culture, and the reason is not simply the effect of aging.

Activity Theory

Perhaps the most popular view of aging holds that older people have the same social and psychological needs as middle-aged people. According to activity theory, the person who ages successfully is the one who resists the circumstances of aging and fights to stay "young." This view holds that older people's isolation, rolelessness, and inactivity have two sources. First, the older person's social world shrinks with retirement, death of spouse and friends, and financial and mobility limitations. Second, the older person's physical decline makes it increasingly difficult for him to overcome these obstacles and to fulfill his needs.

To counteract these trends, the older person should maintain the interests and activities of middle age as long as possible. He shows himself to be dogged and resourceful when pressures force him to relinquish certain involvements. When he retires, he finds new productive activities. When his friends and spouse die, he finds new friends, perhaps younger ones. When illness and frailty limit his physical activity, he substitutes intellectual pursuits. According to activity theory, aging is a continous struggle to remain middle-aged.

Activity theory embodies several value judgments. It presumes that it is better to be active than inactive, to fight against adversity rather than accommodate it. It also presumes that old age is "bad" and middle age is "good." Finally, those who adhere to activity theory, along with all theorists who are concerned with "successful" aging, presume that it is better to be happy than unhappy, and that the aging individual, rather than the observer, is the best judge of his success. In all these presumptions, activity theory is congenial with modern American values.

The evidence supporting activity theory as a general theory of aging is mixed. Most older people try to maintain their usual level of activity as long as they can. It is also clear that older Americans prefer to think of themselves as middle-aged rather than old, and would like others to do so as well. When societal pressures on the elderly are minimal, some older people do in fact seem to seize opportunities for creative activity. For example, one study found that three-quarters of a sample of retired university professors were engaged in a remarkable variety of productive tasks.

However, most older people are not retired professors. Activity theory does not account for the documented decline in older people's levels of activity and the extent of their social engagement as they grow older. Clearly, many older people cannot or will not sustain a middle-aged style of life; they allow their social world to shrink, willingly or under pressure. Furthermore, large numbers of older people manage this transition quite successfully. The gerontologist Robert Havighurst summarizes the situation in this way:

> As men and women move beyond age 70 . . . they regret the drop in role activity that occurs in their lives. At the same time, most older persons accept this drop as an inevitable accompaniment of growing old; and they succeed in maintaining a sense of self-worth and a sense of satisfaction with past and present life as a whole.

Disengagement Theory

Disengagement theory proposes a quite different view of successful aging. First formulated by Elaine Cumming and William Henry, this theory maintains that both society and the individual prepare for the ultimate "disengagement" of death by an inevitable, gradual, and mutually satisfying process of withdrawal from each other. Society wants to disengage its older members so it can avoid the disruption that their deaths would cause if they died while fully engaged in a variety of social roles. Therefore, society institutionalizes retirement and reduces the number of options available to older people. In their turn, older people are most successful if they can accommodate themselves to this process, and gradually relinquish one social role after another. As this process goes on, the older person is released from the constraints of social norms, becomes more centered on himself, and is freer to review and integrate his life in preparation for death. Thus, disengagement theory views old age as a developmental stage in itself, with its own norms and appropriate patterns of behavior; it is not a continuation of middle age. According to disengagement theory, aging is a process which transforms the individual from a middle-aged person centered on society to an elderly person centered on himself.

The value judgment embodied in disengagement theory is that it is preferable to achieve a state of psychological and social equilibrium than it is to resist forces that would shrink the older person's social world. Freedom and happiness are said to lie in acceptance of old age as an integral state of life. This presumption puts disengagement theory at odds with activity theory. It also challenges the work ethic and certain other widely held American values. Most younger people cannot respond positively to disengagement theory on an emotional level. Those who are deeply engaged tend to feel that involvement and activity are the very fuel of life. They find it hard to accept the possibility that withdrawal and passive self-centeredness may someday actually be attractive.

Disengagement theory has provoked a flurry of research and controversy. Most gerontologists distinguish between disengagement as a description of a social-psychological process, and disengagement as a theory of successful aging. "Disengagement" seems to be an accurate term to describe what actually happens as people grow older. With age, people reduce their social and psychological engagement with others. There is little doubt that society does in fact disengage from the older person. Yet, like activity theory, disengagement seems to be a deficient explanation for the full complex reality of personal adjustment to aging. Some older people are happy when they are active; some are happy when they are "disengaged."

Current social trends suggest that disengagement, while possibly an attractive option for *some* older people, is by no means inevitable. It is argued that society is becoming less insistent that older people move to the social sidelines, and that older people now have more resources and more opportunities, as well as a greater inclination to sustain a high level of activity for a longer period of time. Among the current trends are: (1) better health and increased vigor through better medical care; (2) better economic security through Social Security, pensions, and annuities; (3) greater visibility of older people in political and social organizations; (4) retirement at earlier ages; (5) broader involvement of women in economic and social life; and (6) movement toward creating new roles and options for the elderly. One statistic suggests the magnitude of the social change that is upon us. The average American woman is having her *last* child at the age of 26;

she will become independent from her children between the ages of 40 and 45. Surely, she is not likely to disengage, even though she has lost a major life role.

Other Theories of Aging

While activity theory and disengagement theory are the two most comprehensive views of aging, several less formal theories deserve mention. They are not so much general explanations of the process of aging as they are insights into neglected or obscure aspects of the position of older people in our society.

Older People as a Subculture. This view holds that society's negative response to older people forces them to interact with each other across class and other social barriers. It views older people as a subculture, much as urban adolescents, drug addicts, college students, street people, and other groups can be viewed as subcultures. This theory is more a prediction of a possible social trend than a description of what is actually happening among the elderly. As yet, no investigator has uncovered any significant interaction among older people across social class lines. However, this theory, as presented by social critics such as Simone de Beauvoir and Arnold Rose, can offer persuasive and moving insights into the dehumanizing effects of our dislike for old age. "Society looks upon old age as a kind of shameful secret that is unseemly to mention," de Beauvoir says.

Older People as a Minority Group. A related theory holds that older people, by showing a visible biological trait which society dislikes, undergo discrimination as racial minorities do and that they constitute a minority group in their own right. This theory contains an insight. Older people and racial minorities share low incomes, low social status, a poor self-image, low visibility in mainstream society, job discrimination, and other marks of second-class status. Racial minorities and old people are inheriting the central cities as the middle class flees to the suburbs; in some places, they are beginning to make common cause in obtaining better social services and political power. However, the minority group theory does not hold in all situations. For example, age discrimination does not prevent large numbers of elderly men from holding political office.

Identity Crisis Theory. This theory explains the withdrawal and disengagement of older people primarily as a defensive move stemming from failure to find adequate satisfaction in retirement. This view maintains that most people develop their primary self-identity as workers, and that they undergo a severe identity crisis upon leaving their jobs. Unable to rebuild their identities through leisure pursuits, they withdraw. This theory explains the condition of some, but not all, older people.

Developmental Theory: A Model for Aging

The social and psychological withdrawal which disengagement theory attempts to explain has been documented in several personality studies of adult life, beginning about 15 years ago with a detailed inquiry into the personalities of older people in Kansas City, Missouri. While old age does seem to bring disengagement, a number of researchers in the field have been uncomfortable with the suggestion that disengaged older people are the happiest. Their investigations into this matter have laid the ground-work for a developmental theory of aging which contends that adaptation to aging can proceed in several directions, depending on the aging individual's past life. Stressing the continuity of development among phases of the life cycle, some gerontologists have termed this developmental perspective a "continuity" theory.

Developmental or continuity theory attempts to explain something that anyone with a reasonably broad acquaintance with older people probably suspects: that neither activity nor inactivity necessarily brings happiness. Engaged or disengaged older people can be either happy or unhappy, depending on forces more mysterious, or at least less evident, than the simple level of activity in their lives. This impressionistic suspicion has been documented in most personality studies. Their overall conclusion: active and involved older people are more likely than disengaged individuals to be satisfied with their lives. However, disengaged old people can be happy too, and both active and inactive people can also be miserable.

Developmental psychologists have found that personality types remain extremely stable over the life span, at least in terms of the way individuals adjust or fail to adjust to their social milieu. The face the older person presents to the world is very consistent. Within broad limits—barring serious illness or a social upheaval—patterns of aging are predictable from knowing the individuals in middle age.

One of the more intriguing aspects of this stability of personality is its durability in the face of change and adversity. While the older person behaves outwardly much as he always did, age brings very definite and measurable changes in the person's inner life. Older people perceive reality differently. As we have seen, forty-year-olds see their social environment as one which rewards boldness and risk-taking; sixty-year-olds see the outside world as complex and dangerous. Older people also handle their inner emotions differently. They are more preoccupied with the inner life, less sensitive to the subtleties of social discourse, more withdrawn into themselves. They seem to find more satisfaction from the inner life than from outward engagement and accomplishment. What is more, the developmental psychologists have found that this withdrawal into the inner self can be measured as early as the mid-forties, at least two decades before social disengagement becomes noticeable.

These findings have at least two important implications for our perspective on aging. First, they suggest that the spiritual dimension to aging we discussed earlier is something more than a pious hope, something which happens only to Chinese sages and a few rare wise men. While we lack the data to substantiate it, the process of aging may involve a deepening of the inner life as the body undergoes decline. The second implication is that inner changes do not seriously affect social functioning. The individual's personality and behavior patterns become stable over time and he deals with his environment in well-established ways.

One final aspect of the continuity or developmental theory of aging is of special interest to those who deal with the elderly. Most older people want to remain engaged with their social environment. The magnitude or intensity of this engagement will vary with the individual, according to long-established value patterns and self-concepts. In this, older people will behave like younger people or, more precisely, like their younger selves. However, when older people fail to remain engaged with their social environment, the source of the failure lies in the social environment, not in their age. Such factors as work status, health, financial resources, and marital status affect the older person's capacity to lead a satisfying life much more strongly than age does.

CHAPTER 2

PHYSIOLOGICAL AND BIOLOGICAL CHANGES

Although images and concepts of irreversible biological decline dominate the popular view of aging, generalizations about the processes of physiological aging are actually quite risky. On one level, everything seems so simple: all living things degenerate and eventually die. We call this process of degeneration "aging," and we ruefully recognize its characteristic forms.

The deterioration and death of all living things is governed by a universal law of nature called "the law of entropy increase." Put simply, this law states that everything becomes increasingly disorganized as time passes, unless energy is applied to put things back in order. Archeologists can date the age of ancient fossils by measuring how much certain trace elements have deteriorated. Your office and your home will become increasingly disorganized unless someone applies energy to tidy them up. Since energy to put things back in order is not unlimited, the universe itself will eventually reach a state of inert uniformity. So will all life.

But inside these very broad parameters, aging is not so easy to grasp. Each human being ages at his own rate and in his own way. The nursing home patient—bedridden with a stroke, paralysis, and senility—can be aged 60, 70, 85, or 95. Many men and women of 65 are so deteriorated in their strength, skill, and mental abilities that they are suited only for a leisurely retirement, which may soon degenerate into invalidism. But thousands of "older people" seem entirely undiminished in their physical powers. Many of these vigorous older people are highly visible in political office, in academia, in the professions. Most are more obscure, their accomplishments known only to their family and friends.

The rate and pace of individual aging largely depends on genetic inheritance, nutrition and diet, physical activity, and the psycho-social environment within which the person lives. Thus, the process falls under some measure of human control. Biologists have also demonstrated that the processes of aging operate at varying rates *within* each individual, as well as among individuals. Can a 67-year-old woman be called "old" if her heart and lungs function as well as a 40-year-old's? In fact, with one exception, no single physical condition always occurs in all people as they age. The exception is menopause in women, which is also the only *abrupt* age-related change that happens to humans. All other age changes happen gradually.

In a rigorous sense, we speak of probabilities when we speak about the patterns of physiological aging. The probability of death increases with age. So does the probability of contracting certain chronic diseases such as cancer, heart trouble, arthritis, and hypertension. Certainties are elusive. In the following section, we shall describe some of these probable patterns, but an exception exists for nearly all assertions we shall make.

I

PATTERNS OF PHYSIOLOGICAL AGING

We see the progress of physiological aging in changes in appearance over the years. The hair whitens and falls out of the head, while at the same time appearing in new places, such as on the faces of old women. Supportive tissues become dehydrated and lose their elasticity, causing the skin to wrinkle and the teeth to fall out. Growth of excess skin thickens the eyelids; hollows appear beneath the eyes. The upper lip becomes thinner, the earlobes larger. The skeletal structure changes as the body gradually produces relatively more inert connective tissue. The spinal disks compress and bend the spine, causing old people's characteristic stoop. The pelvis broadens, shoulders and chest become narrower and more rigid. These changes in the structure of the upper torso are partly responsible for reducing the respiratory capacity of old people. An 80-year-old individual has half the breathing capacity that he had at age 30.

The characteristic appearance of older people is affected by gradual deterioration in the kinesthetic sense, the ability to move our bodies and limbs in a coordinated way in space. The kinesthetic sense depends on a constant pattern of nerve responses from muscles, tendons, joints, and the inner ear. Aging affects the efficiency of all these nerves and organs, as well as the speed with which the brain processes this constant stream of complex information. Thus, older people have characteristic difficulties in walking and stepping. Older men tend to assume a wide stance and a shuffling walk. Older women often have a waddling gait. The elderly of both sexes have difficulty stepping down from heights. These difficulties are related to declining muscle strength and increasing fragility of bones, as well as to the loss of the kinesthetic sense. Gerontologists employ a simple test of the kinesthetic sense to determine a person's "age." The person is asked to walk on a two-inch wide white line painted on the floor. His difficulty in doing so indicates his age. The very old can walk the line only with great difficulty, if at all, and they often express fear of falling. This test is usually a more reliable indicator of a person's physical age than is his chronological age.

Most people believe that physical aging starts in earnest sometime in middle age. Actually, the most characteristic pattern of physiological age change is a decline that begins at about age 30 and continues for the rest of the individual's life. A plot of certain important physiological functions on a graph would look something like this: metabolic rate, percentage of body water, cardiac output, kidney function, and breathing capacity all reach their peak at about age 30 and decline steadily thereafter, with assorted ups and downs. However, not all of these functions decline at the same rate. Metabolic efficiency will decline only about 10 percent between ages 30 and 80; breathing capacity and kidney function will decline by half. Some functions actually improve with age. Cholesterol, the fatty substance which is thought to contribute to atherosclerosis and heart attacks, reaches its highest concentrations in the blood at about age 55 and plummets sharply thereafter. Other functions—such as the body's ability to regulate glucose levels—do not change at all with age. However, if glucose levels rise sharply, they will return to normal more slowly in an older individual. The example illustrates other important physiological changes with age: the body's energy capacity becomes depleted and recovery from stress and injury takes longer.

These patterns of age-related decline only represent averages. The physiologists who have plotted them always find some individuals who are aging faster than the norm and others who seem hardly affected at all. It must be stressed that these statements describe the general direction of aging, not its universal rules. Furthermore, the relationship between physiological deterioration and human behavior is ambiguous.

Human beings possess an often extraordinary capacity to compensate for the debilitations of age. One British research team found that elderly women in textile factories continue to perform exacting tasks with small threads, even though their eyesight is poor. These women seem to rely on pure physical dexterity and long years of experience to sustain a remarkable level of performance. The same team discovered that the actual age-related decline in strength and reaction time, while evident and annoying to older people, often has a less drastic effect than commonly believed. For example, muscular strength is greatest at age 27 and declines by only about 16 percent over the next 30 years. Coupled with depleted reserve capacity and longer recovery rates, this sapping of one's strength can certainly be troublesome and limiting. Yet the evidence suggests that most people can find ways to compensate for the deficiencies of old age until very late in life.

In other words, aging itself is not a disease. Genuine cases of death from "age" or "natural" causes are rare; some biologists deny that they ever happen. Usually, the age-weakened organism succumbs to an infection or other crisis which a stronger organism would have withstood. Nevertheless, aging and disease are linked in a reciprocal fashion. Just as aging makes the person more vulnerable to disease, disease can hasten the process of aging. Similarly, good health slows down the process of aging.

Perhaps the best way to conceptualize biological aging is to view it as a series of processes which gradually make the body more vulnerable to outside assaults, less adaptable to the environment, and more subject to stress and crisis. This happens because the body—subtly and inconspicuously—loses its resilience. Muscles lose their tone. Tissues, organs, and organ systems become rigid, less elastic, less adaptable to stress. Since the body affects the mind quite as much as mind affects body, this loss of bodily resilience may contribute to the mental rigidity which many older people display. Surely, loss of resilience affects the older person's behavior and thinking as much as declining strength, depleted energy, and other declines in physiological functions.

For example, an older person who steps from a high bus step onto the concrete sidewalk will feel a disagreeable jerk, as if a slack rope were suddenly pulled tight. His muscles have lost their elasticity; he cannot cushion the blow and alight gracefully as a young person can. This loss of resilience, coupled with other losses, places the older person in jeopardy. His bones, skin, spinal disks and tendons are dehydrated and more fragile. Thus, blows, jerks, and falls which a younger person brushes aside often cause serious injury in old people. It is important for the older person to become fully aware of the implications of these subtle biological changes. He cannot expect to bounce back from a blow. He must be physically cautious.

Increasing rigidity extends to the internal organs, the nervous system, and the brain. On every level of the physiological system—cells, tissues, organs, organ systems, and connective tissues—aging brings dehydration. The various parts of the body retain less fluid as they age. Joints stiffen. Chest tissues tighten, making breathing more difficult. The skin dries and is more vulnerable to sunburn, windburn, itches, and irritation. Skin dryness impairs the body's ability to control surface temperature through perspiration. While older people are less readily aware of temperature changes because their nerves function less efficiently, their sluggish body temperature control systems subject them to greater distress from lengthy heat and cold. Thus, they will sit near radiators and wear extra sweaters and blankets in winter, and suffer more than the young from summer heat waves. If they can afford it, many retire to Southern California and Florida to escape distressingly variable northern climates.

Loss of resilience also helps explain why older people cope with stress less effectively. A physical task or stressful challenge will cause a greater disruption in the older person's normal physiological functioning than it will for a young person. The old person works harder, straining to accomplish the task or solve the problem. Afterwards, the older person will recover from the stressful situation more slowly. In other words, aging reduces the body's supply of reserve energy and hampers one's ability to use the reserve capacity he does have. This depletion of physical reserves often has more serious effects on the older person's day-to-day life and behavior than more precisely measurable changes as loss of cells and declining strength.

For example, an 80-year-old person may be able to function quite adequately in a restful, uniform environment, even though tightening muscles, narrower chest, and loss of lung cells have reduced his breathing capacity by about half since age 30. But steady exposure to moderate levels of air pollution and smog may cause him great distress because his lung capacity is stretched to the limit. If he contracts flu or another respiratory illness, he may die precisely because he has none of the 30-year-old's reserve breathing capacity to carry him through the crisis. This example illustrates a cost we often neglect to consider when we talk about "accepting" certain levels of environmental hazard as the price of technological progress. Indeed, M. Vacek, a Czech gerontologist, maintains that the general deterioration of the environment has cancelled out any positive effect from advances in medical science in lengthening the lives of older people. Life expectancy at birth has increased dramatically in this century, but a 65-year-old American today can expect to live less than two years longer than an American who turned 65 in the year 1900.

The older person who survives a medical crisis will recover from it more slowly. On the average, a wound which heals in 31 days in a youth of 20 takes 55 days to heal in a 40-year-old, and 100 days to heal in a man of 60. Thus, minor surgery can become major for an older person. Colds will linger. With each successive winter, the old man will be sicker for a longer time when he gets the flu. He will tire more easily and take a longer time to recover his strength after exertion. All this is true even if the older person is robust and in good health. In a sense, robust health can be deceptive if the older person does not realize that his reserve capacity is diminishing and that he will return to normal more slowly after stress. He must still be cautious and conserving.

This characteristic loss of reserve energy and recovery capacity is caused in large part by an age-related decline in the efficiency of the cardiovascular system. With age, the heart works harder to do its job. The heart pumps less blood with each beat, so it must beat more frequently to carry blood to the cells and tissues. At the same time, veins and arteries lose their elasticity. Circulation becomes less efficient and blood pressure rises. The lungs take in less air and give off less oxygen to the blood cells. The blood itself is capable of carrying less oxygen. Thus, the cardiovascular system gets essential nutrients to the cells in a less efficient manner. Since the blood carries the agents that fight disease and heal wounds, recovery from sickness and injury is slower. Frequently, the cardiovascular system itself will contract disease. Its most serious ailment is arteriosclerosis, the thickening or hardening and eventual blockage of the arteries.

Arteriosclerosis can lead to both heart attacks and strokes. It can also impair brain functioning by reducing the supply of blood the brain receives.

II

THE SEARCH FOR LONGEVITY

Man probably began pursuing the Fountain of Youth as soon as he became aware of aging and death. Certainly, man's efforts to prolong his life are found at the beginning of recorded history. King David of Israel hoped to restore his youthful vigor by sleeping between two virgins to imbibe the youthful vapors they supposedly exuded. Longevity has often been more specifically associated with sexual vitality. In 1926, Serge Voronoff, a Russian-born French surgeon, published a book claiming that youth could be restored by transplanting the sex organs of young animals into the bodies of aging humans. Other visionaries have looked for the cause of aging elsewhere. In the late 1800s, the Russian biologist Elie Metchnikoff declared that poisons released into the body from the large intestine caused humans to grow old. His remedy: surgical removal of the large intestine. To hold back old age, prophets and quacks have searched for youth-restoring springs, injected the gullible with cells from lambs' fetuses, and prescribed an array of elixirs, potions, secret drugs, and medicines for tired blood. When asked about the secret of their great age, centenarians in widely-separated regions where longevity is common customarily cite the local alcoholic beverage.

If man's early attempts to prolong life seem fanciful, recent research into the secrets of the aging process is among the most sophisticated and intriguing being conducted anywhere. It has already produced solid gains in understanding why we grow old. Some biologists, such as Bernard Strehler of the University of Southern California, have found the results so promising that they predict a major breakthrough before the end of this century allowing a substantial extension of human life. Man continues to dream of defeating death. For man the technologist, the control of aging represents the ultimate act of control.

If biologists do eventually achieve a breakthrough allowing adults to live longer, it will be the first science has ever made. Surprising as it may seem, there is no evidence to suggest that an adult reaching maturity today will live substantially longer than any man or woman reaching maturity within the past thousand years. Old people today *do* live longer than their ancestors, but probably not *that* much longer. Today's elderly are less likely to die in a plague, natural disaster, or from an infectious disease such as tuberculosis, smallpox, or yellow fever. They are more likely to die of heart disease, cancer, stroke, or degenerative illnesses. More people survive into old age today because sweeping improvements in public health have made it possible for many more babies to survive infancy and childhood. Ironically, medical science has created a growing population of oldsters by an enormously successful attack on the diseases of childhood.

Research into the disease states of old age is one of three general lines of investigation into measures to increase longevity. Knowledge of the causes and prevention of arteriosclerosis, cancer, stroke, arthritis, and the other degenerative diseases of old age is still very limited, although in some ways very promising. We know that vigorous exercise and a prudent diet can greatly reduce the chances of heart disease. Most cancers can be successfully treated if detected early enough. But to control the diseases of old age is not to control old age itself. Strehler estimates that the complete conquest of both heart disease and cancer would add between 7 and 15 years to the average human life span—a significant increase, but hardly the entree to immortality that man has always dreamed about. The breakthrough, if it comes, will more likely be achieved through the other two lines of research: study of the factors which already produce long lives in human beings, and laboratory study of the reasons why cells and tissues grow old and die.

Why Some Men Live Longer

An evolutionary biologist might conclude that the pain and degeneration of old age is the price man pays for daring to live longer than nature wants him to. From a strict interpretation of evolutionary theory, there is no reason for a man or woman to live after reproductive and child-rearing functions cease. The rule is seen most dramatically in some species of fish which grow old and die within weeks of laying their eggs. Yet humans, especially the female, live well beyond their period of fertility, even though a long life has no direct evolutionary advantage. The only conclusion is that man, consciously or by accident, has already managed to extend his life span beyond what nature would grudgingly give him. To find the explanation, scientists have turned to the study of those who already have long lives.

All scientists who have studied the factors which produce long lives are convinced of the importance of genetic inheritance. Offspring of long-lived parents live longer than those whose parents die young. The first offspring of a union will tend to live longer than those who are born later. Children of parents who contract heart disease and some forms of cancer are more likely to contract these diseases themselves. None of these genetic mechanisms are very well understood.

Genetic factors appear to play a very large role in the long lives enjoyed by residents of two remote and widely separate pockets of longevity—Vilcabamba, Ecuador, and Hunza, Pakistan. In Vilcabamba, a remote village in the Andes mountains, about 7 percent of the population is aged 80 or more. The comparable rate for Ecuador as a whole is far less than one percent. Hunza, an isolated settlement in the mountains near Pakistan's border with China and Afghanistan, also has a remarkable number of vigorous and well-preserved oldsters, many of whom say they are aged over 100. Alexander Leaf, a Harvard physician, conducted exhaustive studies of the older people in these villages and concluded that their genetic homogeneity was a striking influence. Leaf suggests that there are no "good" genes favoring longevity, but only "bad" genes which increase the probability of acquiring a fatal illness. He speculates that a small number of individuals lacking "bad" genes settled in these isolated areas centuries ago and produced a race of particularly hardy individuals. The isolation of Vilcabamba and Hunza has prevented subsequent mixture with "bad" genes.

However, genetic influences seem much less important in a third notable pocket of longevity—in the Abkhasia region of the Caucasus on the Black Sea in Soviet Georgia. The Caucasus is one of the most ethnically mixed areas in the world. There, Leaf found many people aged over 100 who were from Georgian, Jewish, Russian, Armenian, and Turkish stock. The most prominent factor producing long life in the Caucasus appeared to be a high level of physical activity. A Soviet research team found that most of the 15,000 individuals over age 80 in the region were carrying a full load of work on state or collective farms. In Vilcabamba and Hunza, as well as in the Caucasus, physical fitness is an inevitable consequence of the very active lives the inhabitants lead.

Physical activity and fitness is perhaps the best-documented of all the factors that appear to produce long life. A careful study of the effects of a program of graduated but heavy exercise on a group of sedentary middle aged men found substantial improvements in the efficiency of a number of physiological functions that ordinarily decline with age. It was found that exercise brought a lower heart rate, greater pumping capacity of the heart, lower blood pressure, greater lung capacity, more efficient fat metabolism, lower cholesterol levels, and improvements in blood sugar levels. In some cases, the men experienced such unexpected changes as improvements in hearing and vision. Numerous studies have documented the positive benefits of regular physical activity on the heart and lungs. It is now clear that a carefully regulated program of jogging under medical supervision is the most effective way to rehabilitate heart muscles damaged in heart attacks. A very high level of physical fitness may even constitute insurance against heart attacks. A study conducted by the American Medical Joggers Association found that *not one* of the men and women who have run the 26-mile Marathon race within the last 100 years had died of heart disease. Other studies have found that the weekend athlete who engages in regular vigorous physical activity is only one-third as prone to heart disease as his sedentary neighbor of the same age.

Another promising but less certain influence on longevity is diet and nutrition. In the 1930s, researchers at Cornell University nearly doubled the lives of albino rats by restricting caloric intake early in life. Lately, biochemists at the National Institutes of Health have increased the life span of mice by one-quarter by similarly restricting their food. Indeed, manipulation of diet remains the only demonstrable way to extend the life of an experimental animal. However, since restricted diet also serves to delay the animals' growth and maturation, the significance of these experiments for humans remains questionable. Nevertheless, many authorities maintain that these experiments are clear enough to raise questions about the current practice of overfeeding children.

The studies of diet in Vilcabamba, Hunza, and the Caucasus would seem to support these questions, although the evidence is by no means clear. Adults in these regions consume between two-fifths and two-thirds of the average daily American caloric intake of 3,300 calories. This in itself would not seem to explain their inhabitants' longevity, since most people in the world consume far fewer calories than the average American. Perhaps of more significance is the nature of this diet. In all three places, the diet is rich in proteins and low in fats. In the Caucasus, the region where fat consumption is highest of the three, total fat intake is still between 40 and 60 grams daily—compared to the American average of 157 grams. The fat-rich American diet is associated with both obesity and heart disease. In contrast, the low-fat diet of regions where longevity is common is associated with both a high level of fitness and a low incidence of heart disease.

Psychological and cultural influences on a long life are the factors which are most difficult to measure with scientific precision, but they are perhaps the most compelling explanations for longevity. The elders in Vilcabamba, Hunza, and the Caucasus are all productive contributors to the agricultural economy. What's more, old age is honored; in all three of these very different societies, social status increases with age. All three societies are also relatively placid, unaggressive, and firmly rooted in the family and the soil. The contrast with American society could hardly be more vivid.

The Aging of Tissues and Cells

There is little doubt that human cells are programmed to die. Different species of animals have widely varying but seemingly fixed life spans. Leonard Hayflick of the Stanford University School of Medicine documented this programmed death in studies showing that cells will divide some 50 times and then die. Hayflick plunged some cells into liquid nitrogen, freezing them and halting growth. The cells resumed growth later on thawing, but died after completing their apparently programmed 50 divisions. Unraveling this program is the goal of the third major direction of anti-aging research. What is the nature of the "biological clock" that so ruthlessly controls our span of life? How can man control it?

A few intriguing experiments have skirted the edges of this central question. One set of studies, discussed previously, indicates that a reduced caloric intake can drastically increase the life span of certain experimental laboratory animals. Another line of research has shown that lower body temperatures have similar effects. In 1917, biochemists discovered that the fruit fly's life span roughly doubles every time its body temperature is lowered 14°F. The same thing is true for a variety of insects, fish, rotifers, and other cold-blooded animals. Studies of certain warm-blooded animals also show that their cells live longer during hibernation under low body temperatures than they do under normal active conditions. Presumably, this means that warm-blooded animals such as man would live longer if they could permanently lower their body temperatures. To accomplish this, scientists would have to devise a way to safely tinker with man's temperature control mechanism, located in a small section of the hypothalamus gland of the brain.

In a sense, these studies beg the central questions of aging. It is no surprise that lower body temperature will lengthen life because all kinds of chemical reactions, including those involved in aging, slow down as temperature drops. The questions remain: what are these chemical reactions, and how can they be controlled?

Just as a child can identify an old person by his gray hair and wrinkled skin, a biochemist can identify old tissues by glancing in a microscope. Cells in old tissues are simply less *orderly* than those in young tissues. They are arranged in a more erratic fashion—a biological expression of the physical law of entropy increase. Old cells are also discolored by dark substances called lipofuscin, or age pigments. Biochemists think lipofuscin is produced by reactions between oxygen and unsaturated fats in cell membranes—the same process that causes floor varnish to harden and yellow as it ages. Scientists have experimented with compounds called antioxidants which retard the oxidation process producing age pigments. Rats' lives have been extended by about 25 percent by feeding them BHT, a synthetic food additive, which retards oxidation. Vitamin E, another antioxidant, does not seem to make rats live longer, but its absence causes age pigments to accumulate rapidly in young animals.

The accumulation of age pigments in cells is controlled by our genes. In fact, scientists are now certain that genes—the fantastically complex chains of protein which tell our cells what to do—are at the root of all aging. Certain kinds of genes are "switched on" at the precisely correct time in the lives of cells and tissues. On the other hand, certain genes are also "switched off" after a length of time. Since genes are responsible for manufacturing the products which cells need to keep functioning, cells with switched off genes eventually deteriorate. Physiological aging is really the accumulation of this kind of damage throughout tissues, organs and organ systems.

DNA operates in a complex fashion. DNA communicates its crucial instructions through another chainlike molecule called messenger ribonucleic acid (mRNA). The mRNA code copy is deciphered by another form of RNA called transfer RNA (tRNA). The tRNA attaches itself to that portion of the mRNA describing a certain amino acid. Then, with the help of cell structures called ribosomes, the tRNA assembles the correct amino acids one by one until they form the protein contained in the original DNA instruction. In such a complex process, there are many ways for protein synthesis to fail. Nevertheless, biologists already know how DNA is switched off in very simple bacteria. A substance called a repressor attaches itself to the DNA, blocking the formation of mRNA copies. Both cell and DNA are healthy capable of longer life. Yet the repressor prevents the DNA from telling the cell how to continue to make the proteins necessary to stay alive. In theory, scientists could attack the repressor through chemicals once they understand what it is. The organism could be injected with a drug that combines with the inhibitor, thereby rendering it ineffective.

However, the switching off of DNA in higher organisms such as man appears to be much more complex. For one thing, DNA transmits instructions in a sequence appropriate for the cell's stage of development. In other words, substances present in human cells inform the DNA that the cell has reached stage "X" in development and is ready to proceed to stage "Y." The DNA then codes out the proper instructions. Thus, human cells employ a feedback or feed-forward system. This can be defined as a set of regulators which detect the conditions within a system and cause a new set of operations to occur automatically, thereby producing a new state. These regulators are probably heavily implicated in aging. They tell the DNA about conditions in the cell through scores of stages—and then they stop, shutting the system down. The process is further complicated by the fact that the regulators themselves are manufactured by the cell under instructions from DNA.

Nevertheless, biochemists have uncovered at least two ways protein synthesis is thwarted in animals. One series of experiments has shown that the tRNA, which "reads" the DNA instructions from the mRNA copy, fails to go on and assemble the particular amino acid in the proper sequence. Thus, the protein synthesis is aborted, and an incomplete chain of amino acids is released. Another line of experiment has shown that protein synthesis gradually fails because the cells lose ribosomes, the vital cell structure essential for the decoding of the DNA message.

Some biologists, most prominently Strehler, believe that deeper understanding of these failures will eventually permit man to counterattack. Ironically, one possible intervention recalls man's ancient association of longevity with sexual vitality. Certain genes which produce ribosomes seem to be particularly abundant during the later stages of maturation of the sex cells—eggs and sperm—in some animals. These genes are under the control of other genes which are switched off before fertilization. If they could be switched on again, more ribosomes might be produced, thereby increasing the efficiency of protein synthesis and rejuvenating the individual. Strehler suggests that the "turn on" agent might be a specially prepared virus which contains the missing genetic information. It has already been shown in bacteria that certain kinds of viruses are able to transfer usable genetic information from a source to an infected cell. The virus incorporates part of the DNA message of the host-donor cell into its own DNA sequence. Transported to another cell, this DNA can supply coded information instructing the infected cell to produce certain substances.

The prospect of deliberate manipulation of genetic material through viruses and other refined biological tools raises extraordinary moral issues. For example, even if man eventually restores his failing genetic machinery and approaches immortality, he would still lose his personal identity. Unavoidable cellular accidents would gradually destroy the complex arrangements of brain cells which constitute memory. Even if brain cells could be replaced through genetic manipulation, the individual would eventually evolve into an entity which barely resembles the creature it was at an earlier time. As the history of science has shown, important technological advances usually have vast and often unpredictable social and moral consequences. If the manipulation of the genetic program of aging represents the ultimate act of human control, it also possesses the potential for ultimate abuse.

CHAPTER 3

PSYCHOLOGICAL CHANGES

Laboratory psychologists have documented a multitude of psychological changes with advancing age. Vision, hearing, motor responses, and the efficiency of the central nervous system all decline in patterns similar to the decline of physiological functions discussed in the previous chapter. Less precisely measured but still important changes occur in the older person's drives, attitudes, and motives for action. Emotional states, such as loneliness and boredom, and patterns of habit and routine all take on new importance for the older person and for those who deal with him. At the end of old age is death, a reality that every person must eventually confront with whatever emotional resources he possesses.

The importance of these psychological changes is evident. They affect the behavior of elderly people perhaps more intensely than does the aging of their bodies. Here also lurk most of the myths, stereotypes, and cruelties that characterize young people's vision of age: supposed mental rigidity, declining intelligence, inability to learn, senility.

However, two problems run through most of the literature on psychological aging. First, much of the data about age-related psychological changes is obtained in laboratories. These settings are quite divorced from the daily lives of older people. Consequently, data must be interpreted carefully. We also must contend with the opposite difficulty—a lack of precision. Some important aspects of psychological aging—such as the role of habit, loneliness, and motivation—are not often discussed by psychologists because they are difficult to measure and require an imaginative leap into the consciousness of the older person. Nevertheless, we shall attempt to show, to the extent possible, what it feels like to be old, and what effects age-related psychological changes have on the older person's attitudes and behavior.

This chapter is divided into two major sections: changes in performance capacities, and emotional changes. It concludes with a brief discussion of death.

I

PERFORMANCE CAPACITIES

One of the most prominent characteristics of aging is an overall slowing down of performance. This characteristic is by no means limited to "older people." A football player is said to be "old" after age 30 because he cannot execute plays as rapidly as he could when he was six or seven years younger. We can observe a general slowing down even within the more sedentary lives that most people lead. Young parents move around more slowly than their young children. (Where *do* they get their energy?) Middle-aged workers customarily take longer to complete a job than their younger colleagues. The very old are usually very slow—in speech, movement, even in thought. Even though a slowing down begins quite early in life, we tend to associate this trait with old people—precisely because their slowness is so very noticeable.

This decline in performance levels has complex causes. It involves a weakening of the sensory processes: old people see and hear less than young people do. The central nervous system processes sensory information less efficiently. As a consequence, prudent older people adopt habits of caution as they deal with external stimuli. Not certain that they are seeing and hearing accurately or responding appropriately, they wait until they are *sure*. Once again we note the interrelatedness of the processes of aging. Slowness in performance is caused both by biologically-based physical losses and by a social strategy old people adopt to negotiate a more hazardous environment.

The Senses

All the senses seem to diminish in efficiency with age. Cells are lost, chemical and neurological functions are altered, and the sense organs' supporting structures change in a way that further impairs them. The decline of the sensory processes is one of the most familiar, general, and troublesome aspects of psychological aging. The older person receives less sensory information; the information he does receive tends to be ambiguous. Thus, older people are cautious about the messages they receive from their environment. Sensory decline also influences behavior by sometimes filling the older person with frustration. It becomes harder to catch the soft innuendoes in conversation, to hear noises on the street at night, to see street signs and flowers, to taste and enjoy a flavorful dinner. The world's richness, subtlety, and variety gradually shrink. The young can only imagine the effect of these losses.

Vision. A number of physiological and perceptual changes occur in the eye. The lens becomes less elastic and the optic muscles less capable of contracting the lens in order to focus it. Thus, older people have a hard time focussing their unaided eyes on books, newspapers, and close detail. If they forget their reading glasses, many have to hold such material at arm's length to be able to read it. At the same time, the pupil and the retina become less sensitive to light and the eyes shrink somewhat, allowing less light to enter. These changes begin in middle age and even before. A 50-year-old needs twice as much light to see as well as a youth of 20. An 80-year-old needs three times as much light. These two changes—the need for more light and close-in focussing problems—sometimes cause eyestrain in older people. Since bringing an object closer to the eyes increases its brightness, many older people will bring a book closer to their eyes than they should and soon find themselves suffering from the ache of eyestrain. The danger of strain is heightened because all these changes—as well as all changes with age—happen gradually.

Older people can compensate for many of their visual problems by simply increasing the illumination in rooms. However, it is dangerous to illuminate old people's surroundings with table and floor lamps because the old eye takes longer to adapt to changes in light and is less able to discriminate among levels of brightness. Thus, old people will see lamps as spots of bright light surrounded by very dark areas. Strong, diffused, indirect lighting is preferred. For the same reason, old people must take special care when driving at night.

Color vision also changes with age. The eye's lens becomes slightly yellowed and filters out violet, blue, and green colors at the dark end of the spectrum. For old people to get the same satisfaction from color as they once did, the dark colors must be more intense and their surroundings should contain more yellow, orange, and red.

Some visual problems in old people can be quite serious. With age, eyes become more sensitive to glare. Most old people develop a cataract condition which scatters light and introduces a glare effect within the eyes themselves. Glaucoma is also a relatively common disease among old people. About two-thirds of the 500,000 legally blind Americans are over 50 years of age.

Hearing. Hearing loss begins at about age 20 and continues until death. The major part of this loss occurs in the higher frequency ranges. Most "hard-of-hearing" people suffer this selective high-frequency loss rather than a general loss of all hearing acuity which is the common view of deafness. Voices, horns, telephone bells, and door bells should be low-toned and of high intensity for old people to hear them. For the same reason, many older people enjoy organ music with its rich low tones, and typically play stereos, TVs and radios louder in order to hear them. Loss of high-frequency tones also means that the elderly have a harder time catching the subtle tones and pitches of human speech. Their families, friends, and others should speak in even tones to help them catch necessary cues. Older people are also more vulnerable to ear damage through very loud noise. For some reason, beginning at about age 55, the hearing loss in men is much faster than for women.

Hearing loss typically proceeds unevenly and deceptively, complicating the older person's efforts to adjust to it. The older person's impaired ability to hear high tones can go unnoticed—except that the old person frequently complains that everyone mumbles when they talk to him. Another aspect of hearing loss can be equally troublesome. This is the increase in the so-called "threshhold" of hearing. In extreme cases, an older person may be able to hear very little when someone talks to him at a normal level. But when the speaker raises his voice, the older person hears —at the raised level. The older person thus hears others mumbling, then shouting at him.

Hearing loss can produce a very debilitating, crushing kind of isolation, particularly when accompanied by failing eyesight, as is often the case. When the two main senses send weak and erratic signals, it is easy for the older person to become anxious and fearful, to wonder what hazard lies unseen in the hallway, or what innuendo flies past unheard in younger people's conversation. Wilma Donahue, a psychologist, quotes an elderly resident of a modern senior citizen housing complex, a man who missed much of the conversation around him. "I just sit stupidly by," he said in frustration.

However, most older people learn to compensate for vision and hearing loss. As we age, we usually learn to use one or more of four strategies to compensate for what our eyes and ears miss. The first strategy is to use hearing aids, eyeglasses and other devices to amplify and refine the data we *do* receive from our senses. It is, of course, vitally important that these devices be selected with proper medical advice. A second strategy is to learn to use one sense to compensate for the deficiencies of another. This is seen most remarkably in blind people who can maneuver quite skillfully by relying on the senses of sound and touch. The third technique is to arrange the environment so that it gives off stronger stimuli. Examples of this would be to increase the lighting in rooms, to speak to older people in the strong, low tones they hear best, and to decorate their surroundings with stronger colors. The final technique—the one used by perhaps most older people—is to rely on experience to fill in the gaps of sensory data. Thus, an old person talking with a friend will rely on his memories, habits, and past experiences of the friend to compensate for imperfect hearing in the conversation with him.

Other Senses. A 70-year-old man has about one-sixth the number of taste buds a 20-year-old has. Taste buds also become less sensitive. Though the sense of taste declines after age 50, major changes in taste do not occur until after age 70. Old people require more highly seasoned food to receive taste satisfaction from it, and they seem to prefer tart tastes to sweets.

Older people have a harder time maintaining their balance. Psychologists think the cause might be inadequate blood supply rather than failure of the inner ear. The central nervous system may also be less efficient in making the subtle, unconscious reflex movements which maintain balance.

Sensitivity to touch increases from birth to about age 45 and declines thereafter. Nerves in the skin are less sensitive to pain. Age also brings a tendency to misjudge the direction of body movements, as with the old person who accidentally spills a glass of wine at table. It is not known whether the sense of smell declines with age.

Environmental Impairment

The weakening of the senses creates an overall effect which is much subtler than the sum total of specific sensory losses. Older people are simply less *aware* than they once were. This change—called environmental impairment—is not often discussed in psychological literature, but it is one of the most important effects of psychological aging.

To understand environmental impairment, try to grasp your field of awareness at this moment. You are now reading a book, and presumably concentrating on these words and ideas. Perhaps your home or office where you sit reading is totally silent, your are completely alone, and no one else is moving about other rooms or on the street outside. However, it is more likely that a multitude of other things in the area are poised to distract you—newspapers and books around your chair, children in other rooms, someone walking in the street outside, a noisy automobile, the telephone, someone cooking in the kitchen.

If you are older—say, 60 or over—you are probably less aware of these surroundings than your children or younger friends would be. Concentrating on this book, you are less likely to hear someone call you from another room or to see someone come up silently beside you. You may be able to grasp ideas expressed in the book as well as you ever did, but you probably don't grasp the peripheral surrounding environment as well as you once could.

As we age, the field of our awareness becomes narrower, the periphery fades. This so-called environmental impairment explains many small traits that we come to think of as characteristic of older people. It explains why old people often seem to be preoccupied, their attention riveted on one thing to the exclusion of everything else. It explains why they can apparently not notice small but important matters of appearance, such as spots on clothes and missing buttons. Because of environmental impairment, old people can lose the thread of conversation, go to bed without turning off the lights, or leave the house without locking the doors. More ominously, environmental impairment helps explain why many older people trip over rugs, fall down stairs, and suffer other accidents that younger people can easily avoid.

Younger people often attribute these mistakes and errors to mental incapacity. They see such behavior as a sign of "slipping" or senility. Actually, older people can appear to be preoccupied, forgetful, and rigid, not because their mental processes are crippled, but because they become less tuned in to the subtle cues that lurk on the periphery of our consciousness. Thus, an older person is less apt to notice the loose rug he may trip over, the absence of a railing on steep stairs, or the subtle but meaningful overtone in a conversation.

Much of the loss of vision and hearing with age occurs at the periphery —the environment that gives proportion, relevance, and background to what is in the center of attention. As the individual gets older and receives weaker signals from his senses, he is forced to rely more heavily on inner preconceptions to build faint sensory clues into full perceptions. Thus, an older person may mistake one friend for another, pick up someone else's coat, and see birds and animals which turn out to be leaves and shadows.

Caution and habit are the two major strategies to overcome the effects of environmental impairment. The course of wisdom for an older person is to form the habit of treating perceptions as tentative and of not relying on them until he has thoroughly checked them out. The old person should also form the habit of becoming extremely cautious and alert to danger signals when he is driving or negotiating an unfamiliar environment. Many old people use routines and habits to compensate for declining sensitivity to subtle cues. Thus, one can regularly send clothes to the cleaners, check lights before going to bed, make lists of chores, and establish a daily routine to get everything done. Such habits may not be worthwhile for all older people, but they can be a major help for many.

Younger people can help their elders in this task in many obvious ways: by speaking distinctly, giving old people adequate time to respond, reminding them tactfully of oversights, and respecting the caution and habits older people use to compensate for environmental impairment. Perhaps younger people's greatest contribution is to recognize that the dimming of awareness is a normal part of aging—not a sign of senility—and that its effects can largely be overcome.

Speed of Response

As we age, we undergo a general slowing of our response to sensory stimuli. Psychologists are not sure why this happens; the dynamics of psychomotor response are very complex and poorly understood. This process includes taking sensory input, understanding it, integrating this understanding into the mind, making a decision about it, sending appropriate signals to muscles to act, and then executing muscle movement. This process can be as simple as turning the next page of this book, or as complex as successfully intercepting a pass in a football game. The roadblock older people encounter seems to lie in the middle of the process, in the processing mechanisms of the brain. The older brain seems to take a longer time to understand the stimuli, make a decision about it, and send the proper instruction to the muscles. The more complex the stimuli, the longer the lag in response.

However, it is important to put this into perspective. Studies also show that older people perform just as well as young people when they have adequate time to complete a task. In fact, data about speed of response is colored by the inherent artificiality of the scientific laboratory setting, and by older people's preference for care and accuracy. Older people tend to take more time checking results and making sure they are on the right track. Thus, some of old people's slowness in response may be attributed to their quest for certainty, whereas younger people are satisfied with rougher accuracy.

Whatever the cause, those who deal with the elderly need to take their slowness into account. If we suggest that an old person should do something, he will take longer to make up his mind and then to act on his decision. The more complicated the task, the longer will be the time necessary for a response. Unless complex suggestions and instructions are repeated and reinforced, old people may not be able to respond at all.

Two final points on this topic. First, many old people have difficulty understanding that they cannot command a young person's split-second response to a complex sensory situation. Those who work with the elderly can help them accept their slowness and consequently help them avoid broken hips, pedestrian accidents, and endless frustration. Second, slower motor response with age does not bespeak "senility," "slipping," or any of the scare words young people use when they notice that the old react more slowly. Except when there is organic brain damage—a very specific condition usually caused by strokes and found most frequently among the very aged—mental processes work well for normal situations. What we lose with age is speed. Although we prize this trait highly, we can compensate for it.

Mental Functioning

Learning and Intelligence. One of the most durable cultural stereotypes about aging is the notion that old people cannot learn, change, and grow. The popular view has it that the young are curious and alert, while the elderly are slow, apathetic, and unwilling or unable to assimilate new ideas.

Regrettably, many old people fit the stereotypic description. Yet the stereotype of the rigid oldster is elevated to the status of myth and applied to all older people because it has over the years acquired a measure of scientific support. Thus, it has become deeply ingrained in our culture, and has important practical consequences for the way our society has arranged its institutions to meet older people's needs. The belief that old people cannot learn is a reason why social workers, counselors, therapists, group workers, educators, community organizers, and others who provide services pay little attention to the needs of old people. All therapy—and much social service—rests on the assumption that change is possible. If those who work with the elderly believe that their clients cannot change, they are likely to seek other clients. In short, the belief that learning stops with advancing age is an important component of the generally negative view of age that pervades our culture.

The "scientific" basis for this belief, once so formidable, has vanished within the past decade. It has been replaced by a growing body of evidence that attributes differences in intellectual performance between old and young to social and educational factors, not to an innate biologically-based decline in mental ability with age. Because the myth remains so influential, it is worth reviewing this upheaval in scientific thinking in some detail.

The early psychologists who established the basis for IQ testing also established "learning curves" which viewed intelligence in the later years very pessimistically. In his classic study of adult learning published in 1928, Thorndike determined that peak learning performance occurred at age 22 and declined about 1 percent a year until age 40. Subsequent studies confirmed this finding, and extended the decline into the sixth and seventh decades.

Psychologists began to suspect something was wrong with this learning curve when they compared it to the educational levels of the individuals whose IQ was being measured. The two curves matched almost exactly! In other words, people "lost" intelligence at about the same rate that their level of education declined. Since older people are always less formally educated than younger generations at any one point in time, their IQ scores are correspondingly lower. The point was emphasized by psychologists who noted that IQ tests themselves are largely validated by the subsequent performance of tested individuals in formal educational settings. Performance in the classroom may be one measure of "intelligence," but it is hardly the only measure, or even the most important one.

The learning curve stonewall began to crack when psychologists concluded that they had been making the methodological mistake of comparing apples and oranges. That is, they had been looking at the IQ performance of very different populations at the same point in time, and concluding that differences were attributable to decline in innate intelligence. In 1955, Terman and Oden tracked down and retested a group of middle-aged men and women who had first been tested as gifted children decades before. They found a much different curve: measures of conceptual thinking had improved over the years.

In a study covering a wider interval of time and a more varied population, Owens located hundreds of middle-aged men and gave them the same intelligence test they had taken when they had been inducted into the U.S. Army 30 years before. He discovered that this group of 50-year-olds had gained slightly in their intellectual ability. Retesting them again 10 years later, he found that the 60-year-olds had maintained their learning capacity. After discounting the records of 60-year-olds who had suffered strokes and other brain damage, Owens suggested that the improvement in learning ability he had found previously continued into the seventh decade.

Recent research has confirmed this suggestion that the truly precipitous drop in intelligence among brain-damaged elderly artificially lowers the overall performance of older age groups. The Riegels found that a sudden, sharp deterioration in IQ in German elderly was a good indication of impending death. They called this phenomenon the "terminal drop," and suggested that it partially explains the poorer performance of older groups when they are compared to the young. The logical conclusion is evident: if health is maintained, intellectual ability will be maintained.

Baltes and Schaie have been conducting the most thorough long-term investigation of intelligence in later life. Their preliminary findings all but destroy the old learning curve, and thus any scientific basis for the myth that learning ability declines with age. Baltes and Schaie have studied long-term changes in four measures of intelligence. The only function that declines with age is visuo-motor flexibility—the ability to shift among a series of tasks requiring coordination of visual and motor abilities. This decline is probably linked to the familiar slowing of motor responses with age. On two other measures of intelligence, Baltes and Schaie found no decline. These are cognitive flexibility, or the ability to shift from one way of thinking to another as with synonyms and antonyms, and visualization, or the ability to organize and process visual materials. Finally, they found a definite, measurable improvement in crystallized intelligence well into the seventh decade of life. Crystallized intelligence consists of skills acquired through education, experience, and acculturation—skills such as verbal comprehension, numerical skills, and inductive reasoning.

McClusky summarizes the implications of these studies in this fashion. First, if a person remains healthy and uses his skills and abilities, he is likely to maintain them at a high level until very late in life. Second, older people tend to show a more complex and varied pattern of performance than the young. In other words, some functions decline while others improve. This establishes a scientific basis for the often-observed capacity of old people to compensate for their losses. Finally, decline *per se* does not necessarily support a negative interpretation. If, as Baltes and Schaie have found, old people show a weakened ability to coordinate visual and motor tasks while they improve in skills depending on education and experience, who is to say that a decline in intelligence has taken place? In the long run, performance has probably won a net gain.

Older people not only retain the *capacity* to learn; their levels of intellectual performance can measurably improve in the proper settings. Experiments have indicated that hyperbaric oxygen treatments to increase the oxygen supply to the brain improve short-term memory in older people. Similar results have been noted as a side effect of treatment for hypertension, and through biofeedback techniques which can train old people to condition their brain waves.

In the proper educational settings, older people's performance improves if they are allowed to have as much time as they want to complete a learning task. In fact, Eisdorfer found that increased time to complete a task improves older people's performance to a greater degree than for young people. People seem to become more responsive to auditory stimuli as they grow older. The most effective learning environment for the elderly appears to be one which combines auditory and visual information, frequent repetition, a leisurely pace, and rewards.

In short, the differences between older and younger learners seem mainly behavioral. Faced with a learning problem, young people will tend to begin to solve it immediately without a clear idea of what they are going to do. They will take a hit-and-miss approach, adopting and rejecting strategies until they hit on the correct one. In contrast, old people will ask many questions and try to think the problem through before starting to solve it. Once underway, they will check their progress frequently. Given enough time, older people are just as likely to find the correct solution as the young. This pattern appears to be a perfectly efficient way to solve problems and acquire new skills. A choice between the hit-and-miss strategy of the young and the deliberate approach of the old is purely arbitrary.

Memory. Studies do not support the notion that all kinds of memory decline with age. The size of a person's vocabulary continues to grow throughout life. He seems to undergo little loss of ability to recall events of the past. However, older people seem to suffer a weakening of the short-term or immediate memory, which provides very quick recall after a delay of between five and thirty seconds. The greatest change seems to come in memory which involves the formation of new associations, as in learning a new language. Recall is improved if older people are given ample time to learn. As people age, they seem more able to recall things heard than things seen, and oral and visual stimuli used together yield best results of all.

Intellectually active people show substantially less memory loss with age, and some older people appear to escape memory loss altogether. This suggests that memory loss is associated less with the processes of aging than with level of activity.

Thinking and Creativity. Older people seem to be less able to generalize from specific data and to form abstract concepts. Confronted with several items of the same type—for example, with five slightly different sheets of paper—an older person will be more aware of the specific differences among them than a younger person will. Some psychologists say that this emphasis on the concrete inhibits older people's capacity to form abstract ideas. However, others argue that weakness in abstraction also reflects the type of education older people received in an earlier America. The recent findings in intelligence and learning suggest that we should be cautious with assertions that old people think less effectively.

Creativity—the process of highly original thinking—is too elusive a concept to measure with much precision. However, under any definition of the term "creativity," nearly every field of human endeavor abounds with examples of highly creative work by individuals in advanced old age. The aged Pope John XXIII and Mao Tse-Tung have become major figures in the history of religion and politics. Artists such as Goya, Verdi, Picasso, and Casals completed masterpieces in their 80s and 90s. Oliver Wendell Holmes, a great justice of the Supreme Court, did some of his most creative legal thinking in his 80s.

Nevertheless, creative thinking which leads to scientific and artistic breakthroughs appears to come relatively early in life. Lehman's studies of age and creativity demonstrated that the genius is likely to be a young man or woman, most probably aged in the 20s and 30s. After these years, creative output falls off. However, this finding by no means leads to the conclusion that the mysterious psychological processes involved in creativity atrophy with age. Abelson has suggested a social rather than a psychological explanation, at least in the case of scientists. In science, important problems are often solved by young investigators shortly after or even during their period of intense intellectual growth in graduate school. After the major breakthrough, the young scientist is presented with a dilemma. He can settle into a role as a new scientific authority, zero in on the remaining smaller problems, and acquire numerous responsibilities involving research grants, graduate students, and departmental administration. Or the young genius can move into other fields. To do this, he usually must leave a secure career and return to school. Thus, decline in creative output with age may well have social rather than psychological roots.

II
EMOTIONAL RESOURCES

Drives

Drives are those inner states of tension and restlessness which provide a very strong predisposition to action. The major drives are hunger, thirst, sex, and that restless activity which is often called curiosity.

Many psychologists believe that older people's drives are less strong than those of younger individuals. However, the intensity of inner drives has been studied primarily by noting the frequency of the overt behavior thought to be associated with them: hunger—eating, thirst—drinking, sex—sexual intercourse, activity—spontaneous bodily movement. Yet the connection between inner drive and overt behavior is ambiguous. For example, lethargy in old people may be caused as much by a dull environment and declining physical energy as by a decline in the inner drive to be active. Again, the social environment may be as influential as psychological shifts and changes in drive-associated behavior.

The best documented of these changes is the decline in sexual activity with age. Many studies show that sexual activity declines with age in a consistent fashion. However, it is impossible to attribute this decline to a simple reduction of the intensity of the sexual drive. In their study of human sexual response, Masters and Johnson concluded that social-psychological factors were more powerful inhibitors of sexual activity than biological aging. These factors include boredom with one's partner, preoccupation with career and money-making, physical and mental fatigue, overindulgence in food and drink, mental illness, and fear of failure. Also influential is the feeling in our culture that love-making among old people is astonishing, and somewhat shameful.

Masters and Johnson's studies indicate that old people are fully capable of sexual activity into their seventies, eighties, and even beyond, despite social-psychological obstacles and physiological decline. Men seem to experience a decline in responsiveness and reduced intensity of pleasure during sexual activity. After menopause, some women experience painful orgasm because of a hormone imbalance, a condition which can usually be treated quite successfully. Nonetheless, sexual activity does decline with age. Although older people retain their physical capacities and desires, the other obstacles to sexual expression can be truly insurmountable.

Many old people bitterly regret the loss of sexual opportunities, for an active and satisfying sexual life has much to do with the way the individual views himself as a man or woman, how he views his body, and his capacity to engage in intimate relationships with other people. For some old people, the termination of sexual activity can hasten or initiate a withdrawal from all intimacy and emotional involvement.

Motives

Desires for continued growth, self-expression, and achievement persist well into old age. As the psychologist Wilma Donahue asks, "How else can you explain the fervor displayed by many old people as they struggle for places of power in their golden age clubs and centers?" These positive growth motivations seem to influence the aging process itself. Psychologists who have studied the age-related declines in many psychological functions admit that old people who remain active and engaged seem able to preserve their intelligence and memory substantially intact until very advanced age. There seems to be no point where primary drives to undertake new projects, to interact with other people, to broaden one's life, entirely cease.

Yet these motives are usually not as prominent in old age as they are earlier in life. Most old people seem to hold these growth motives in a balance with opposite motives—desires to obtain security and relief from anxiety. While they remain interested in growth and self-expression, they must also cope with a precarious social environment made dangerous and uncertain by declining physical and mental powers. Unless the old person can arrange his life so that he feels secure, he is vulnerable to frustration, fear, unhappiness, and maladjusted behavior. Most of the old people whom social service personnel encounter are motivated by desires to simplify and secure their environments. Once they feel safe, the drive for self-expression can be satisfied.

Donahue illustrates this point with the story of an old man she met in a senior citizen housing complex. When he first arrived, the man feared having his second heart attack and wanted only physical security and access to others. To achieve such security, he was willing to give up his home, move into an apartment complex, and build a whole new network of social relationships. Having achieved security, however, he began to display other motives. He wanted to be considered the best housekeeper in the building and waged a vigorous though unsuccessful campaign for election to the tenants' council.

Attitudes and Interests

While older people tend to have different attitudes than younger people, it is difficult to attribute these differences to the process of aging. People now over 65 grew up in a different culture. They were reared in an America dominated by small town and rural values, an America without today's technological wizardry, mobility, and affluence. Many are immigrants or the sons and daughters of immigrants. They were educated in schools which stressed rote memory and recitations, and probably completed their schooling in about the eighth grade. They experienced the harshness of the Depression and of two world wars, and they have seen their society change almost beyond recognition in these last 25 years.

The impact of such historical and cultural factors on older people's attitudes is obviously great. They may have more telling effects than the experience of growing old. For example, most Americans probably hold the belief that people become more politically conservative as they grow older. There is little evidence to support this. Political attitudes remain remarkably consistent over the years. Older people seem to be more conservative mainly because they hold political views formed 40 and 50 years ago, a time when today's social legislation would have seemed wildly radical.

Most studies of attitudes and interests compare old people and young people at the same point in time. Somewhat surprisingly, older people seem more favorable toward persons of other races and are less fearful of death than the young. Their lack of status in a youth-oriented society may render them more tolerant toward other low-status groups. When asked their opinion about the greatest fear old people have, young people named "fear of dying," while for old people the greatest fear was becoming poor. In general, old people are quite sensitive to the attitudes of the young and value their acceptance highly.

Old and young people in America show a remarkable similarity in their interests. The only activities which show significant declines with age are those involving vigorous physical activity. For all Americans—young and old, rich and poor—their primary leisure-time activity is watching television. However, there are some important differences. Older people tend to prefer *serious* content in their TV-watching and reading, while the young are more inclined toward entertainment and fantasy. Movie-going falls off rapidly after age 50, and old people also attend the theater, concerts, and sports events less frequently. (The high cost of an evening out may partially explain this decline.) Although there are notable exceptions, older people do not ordinarily take up creative, autonomous activities such as highly intellectual reading, serious music appreciation, painting, sculpting, or writing. If they did not learn these things while young, they are unlikely to undertake them after retirement. Interest and activity patterns remain very stable over the life span.

These findings have significant implications for those who are concerned about the relatively unimaginative, passive leisure pursuits and interests of older people. Since activities and interests remain relatively stable, change does not come easily in old age. For those interested in effecting change, the target group might very well be young adults: men and women who invest most of their time in jobs and family life and rely primarily on television for relaxation.

Habits

Habit plays an important part in the stabilizing process that seems to come with age. The days and weeks become ordered precisely. The old person may eat the same kind of food, walk the same route to the same store, see the same friends at the same time, view the same television programs week after week, and receive visits from his children after church every Sunday.

Habits are obviously useful for everybody, young and old. A sensible routine relieves us of the need to waste time and energy making decisions about trivial matters. For the young, routines are utilitarian. The rules are flexible. Satisfaction comes from breaking rules, trying a new restaurant, rearranging the living room furniture, or cooking an exotic meal. Yet old people tend to look upon new things uneasily, and habit plays an increasingly important role in their lives as the years go by.

For the idle person, a meticulous daily routine answers the terrible question, "What do I do now?" before it can be asked. Routine gives purpose, meaning, and a certain inevitability to a day which is actually purposeless and empty. Habit also takes on importance for old people because they perceive time as passing more quickly than younger people do, and are more conserving of their use of time. (It is not clear whether old people's sense of quickly passing time is caused by a change in mental processes, or is simply due to their awareness that they have less time left in their lives.) Some old people will use habit aggressively, imposing a meticulous household routine on others in order to wield a little power over the distrusted young. Still others use habit to good effect to compensate for a failing memory.

Those who intervene in old people's lives need to approach their habits with great tact and sensitivity. Old people may find an invitation to visit a downtown welfare office quite impossible to respond to even though they appear to have the necessary strength and time. Abrupt interference with the old person's habits can be quite lethal. Recent studies have shown that relocation of sick and disabled elderly without proper preparation can lead directly to their deaths. For them, familiar surroundings, friendly faces, and a predictable routine provide a structure essential to life itself.

Habits can also be highly maladaptive. The old person can get in the habit of having habits. While habits help relieve the anxiety of old age, maintaining an intricate structure of routine and schedule against unavoidable outside assaults can be the most exhausting and anxiety-producing task of the old person's life.

Loneliness

While most people are subject to periodic feelings of loneliness, the old are probably more vulnerable to these feelings than any other population group. Deprived of long-established associations through the death of spouse and friends, retirement, failing health, near or actual poverty, older people are susceptible not to one loneliness but to many lonelinesses. Studies indicate that acute loneliness is a widespread feeling among older people. About one-third of the older population—approximately seven million people—suffer some form of loneliness to which they will admit. Those most prone to loneliness are the recently widowed; widows with children whom they seldom see; and the physically disabled and homebound.

Surprisingly, the sources, nature, and effects of loneliness are seldom dealt with in standard texts of psychology and psychiatry. Other emotional states such as anger, love, and joy are analyzed in great detail, but loneliness—one of the commonest emotional states— is usually dismissed as a minor maladjustment, stemming from failure to establish satisfactory interpersonal relationships. However, loneliness is a devastating experience. If prolonged, it can lead to serious consequences. John Sheldon, an English gerontologist, says that when older people are lonely, "there is no question whatsoever that their physical health deteriorates."

Actually, both pathological and more benign types of loneliness have two main sources. The first is a longing for a companion with whom one can confide and share an understanding and concern. The other source is fear of being left without such a sympathetic companion.

Obviously, the very nature of aging in American society makes older people more vulnerable to the loss of companions and, consequently, to the fear of future losses. In fact, among the losses suffered by people as they age, the loss of a confidant appears to be far more devastating to their morale than does the loss of social or work roles. Studies show that if older people have even one intimate relationship, they are relatively impervious to the negative effects of retirement, widowhood, reduced participation in social activities, and loss of family and other work roles. The only personal circumstance which does not seem to be buffered by having a close confidant is that of a major physical illness. Many ill older persons experience a depression so deep that they cannot share it successfully with another person.

Loneliness seems to be closely related to the individual's personality and his level of activity. Old people do not feel lonely simply because they are isolated. In one recent study, half of a sample of old people who lived alone declared that they rarely or never felt lonely. Ironically, these people, many of them lifelong "loners"—confirmed bachelors and spinsters, and itinerants—seem better equipped than more socially active people to confront the social isolation that is imposed on so many older Americans. On the other hand, people living in nursing homes frequently complain of loneliness, even though they are surrounded by other people.

In their anthropological study *Culture and Aging*, Margaret Clark and Barbara Anderson found that well-adjusted old people who have a number of satisfying personal relationships with others are also more likely to admit that they enjoy being alone at times. They are secure enough to limit their socializing to relationships they enjoy, and to dispense with the tedious relationships they might have tolerated in earlier years to please one's office colleagues, pacify the neighbors, or humor one's spouse. On the other hand, poorly-adjusted old people tend to seek solitude in order to avoid other people. Their isolation stems from long-standing personality difficulties. Said one woman, "I don't enjoy being with anybody or being alone either."

Clark and Anderson also found that women complain of loneliness more frequently than men, even though they ordinarily have more social contacts. The obvious reason is that older women are, in fact, more lonely. They are more likely than men to be widowed and to be living alone. In addition, women seem to be less inhibited about admitting their loneliness.

A final observation concerns the relationship between loneliness and boredom. The meaning of loneliness seems to change with age: middle-aged people think that loneliness means the absence of *interaction* with others while to old people it means the absence of *activity*. The emotional isolation felt by so many old people seems to be closely related to states of boredom and apathy which are born of indifference, of having nothing worthwhile to do, no goals, no plans. In this, the loneliness of old people and adolescents appear to have similar roots. Both often feel cruelly isolated from other people because they have no creative outlets, no direction, no status in the world of productive, busy adults. A difference, however, is that the state of loneliness is often permanent for old people. Boredom feeds on itself, becoming so deep that it extinguishes all hope and even all desire to escape from it. In her book *The Coming of Age*, Simone de Beauvoir quotes an example of this utter alienation from the diaries of the novelist Andre Gide:

> Yesterday in the train I suddenly found myself quite sincerely wondering whether I were really still alive. The whole world was there and I could see it perfectly well: but was it indeed myself that was seeing it? . . . Everything was existing and continuing to be without my help. The world had not the least need for me. And for quite a long period I withdrew myself.

III

DEATH

Perhaps the last remaining taboo subject in our culture is the subject of death. As we all know, death will come to us all. Most of us have already been grievously affected by the death of relatives and friends, and we will be so affected again and again before we die ourselves. Death is as natural as birth, growth, maturity, and old age, an inescapable part of life.

Yet most people do not think about death in any way. Most people die without even leaving a will. Even those who think they have mastered the fear of death are still frightened by it. Medical people and hospital chaplains who work extensively with dying patients note that no man is ever fully reconciled to the end of his life. Even those terminally ill people who seem most peaceful toward the end always leave a door of hope open: perhaps death won't come this time. Maybe I'll be allowed to live.

Psychiatrists say that this universal human fear of death is rooted in the unconscious. No matter how mature our conscious awareness or our mortality, our unconscious mind can never grasp it. On the instinctual, emotional level, death is always bad—an inconceivable, outrageous necessity. Man has expressed this fear in many ways throughout his history. Primitive peoples would beat drums and shoot arrows into the sky after someone's death, so as to scare away the evil spirit that was stalking about. The origin of the tombstone may lie in an old custom of piling rocks on a grave to keep the bad spirits under the ground. Many cultures have elaborate mourning rituals. The dead person's family and friends tear their clothes, cover themselves with ashes, and wail pitifully. This expresses loss, but it also expresses the fearful knowledge that death will come to the mourners too.

Our own modern culture has its characteristic ways of denying death. About half of all deaths in America occur in large general hospitals and a smaller but increasing number in nursing homes. Fewer than a third die at home, at work, or in public places. The general hospital is not a very good place in which to die. Most medical professionals in hospitals are preoccupied with administrative matters and with the complicated technical aspects of keeping people alive. In these impersonal surroundings, the dying person is usually isolated and lonely. He is going where no one wants to follow, and those around him usually prefer to deny that the journey is taking place at all.

Medical technology and the aging of the American population further complicate the process of dying. Only a few generations ago, most people died swiftly at home, often of an infectious disease, surrounded by family and friends. The medical profession struggled endlessly against these untimely deaths—with considerable success. Today, two-thirds of the American population reaches the age of 70. As a result, most will die of the slow, chronic illnesses prevalent in old age. At the same time, technology continues to expand. Machines, tubes, electronic devices, and other innovations can substitute for most of the old body's failing life-supporting functions.

Of growing importance is the question of when or whether treatment should be withdrawn and when attempts to keep a dying patient alive at all costs should cease. No less a moral authority than the Pope has said that the physician is not obligated to use "extraordinary means" to keep alive a person who has no hope of recovery. Most proponents of this view interpret "extraordinary" to mean "inappropriate in the circumstances." The most extraordinary measures are certainly appropriate when the patient is a young person who has been in a serious accident. The same measures may not be appropriate when the patient is elderly, terminally ill, deteriorated, and in a coma. The "no extraordinary means" position is sometimes called "negative euthanasia," or the withdrawal of treatment from a patient who is likely to die somewhat sooner as a result. It is sharply distinguished from "positive euthanasia," which involves taking active measures to kill a hopelessly ill patient. Although positive euthanasia has earnest adherents, most physicians and laymen recoil from it.

To Help the Dying

Elisabeth Kubler-Ross, a psychiatrist who works with dying people, recalls visiting a moody dying man in the hospital. The doctors and nurses treating him thought Ross would have trouble. The man was withdrawn, never asked a question about his condition, and greeted everyone with a solemn and somewhat frightening manner. Surely, they said, he does not want to talk about death. He probably had no idea that he would soon die. Ross approached the man, introduced herself, and asked, "How sick are you?" "I am full of cancer," he replied, and they talked at length about his life, his death, his fears, and his hopes. Ross commented that the man acted the way he did because no one had ever asked him a direct question.

It seems that our society is becoming increasingly able to ask direct questions about death. Newspapers and magazines publish numerous articles about death and dying. Church groups discuss death. Academic journals treat death from their specialized angles, and associations of professional people launch programs to train their members in working with dying people. At the very least, such discussion should make it easier to discard the old taboo about mentioning death. At best, it may lead to a more mature and humane approach to helping the dying patient.

Already, some of these new approaches are starting to emerge. While advances in medical technology assure most of us long, healthy lives, they also assure that most of us will die in large general hospitals, surrounded by expensive equipment, under intensive care, and separated from all that is familiar. Growing efforts are underway to move the dying out of the hospital and into a more normal environment. In England, many dying people are admitted to special "hospices" where they are cared for by nurses and doctors with special training in treating the dying. These professionals try to create an atmosphere of understanding, confidence and hope, most notably by inviting the dying person's children and grandchildren to spend time at the hospice and surround him with the bustle of normal life.

The English hospices also try to demonstrate the practicality of keeping many dying patients at home, where the dying person and his family are frequently happier. Home care is usually less costly than protracted stays in the hospital, nursing home, or other institution. Unfortunately, Medicare, Medicaid, and other American health insurance programs are not designed to help keep dying people in their homes. For this to be feasible on a large scale, most families would need funds for special beds, wheelchairs, and other equipment necessary to care properly for a dying person.

On another level, doctors, nurses, and other medical people are waking up to the needs of their dying patients. Medical personnel face special problems in this area because the thrust of their training—indeed, the whole thrust of medical science—is toward prolonging life. This emphasis leaves them unprepared to face the inescapable ethical questions that arise during the management of a terminal illness. It also hampers their personal ability to conduct the delicate but crucial relationship with a dying patient.

Elisabeth Kubler-Ross's program to train hospital staff to deal with the dying patient has become a prototype of similar programs spreading throughout American hospitals and medical schools. Although Dr. Ross has studied the process of death with considerable intellectual rigor, her success and influence are probably mostly attributable to her sympathy and dedication. There is considerable hope that the next generation of physicians, nurses, and administrators will be more responsive to the special needs of the dying than their predecessors are.

In her book, *On Death and Dying*, Dr. Ross draws two conclusions from her work which are pertinent here. First, we help dying people die by helping them live. This means we treat them as human beings—not as things or medical objects. They need honesty, love, and consideration. Second, we are most able to help dying people when we make an honest and regular effort to confront our own mortality—to think about our own deaths. This seems to free us to help the dying and live ourselves.

CHAPTER 4

SOCIOECONOMIC CHANGES

The third set of forces which affect the individual as he grows older in years consists of the changes in his role and status within society. In contrast to the gradual and variable changes in physiological and psychological processes, the socioeconomic changes with age are typically abrupt, and they tend to treat all older people the same way. By the age of 65, most workers are retired and adjusting to a new lifestyle centered around rest and leisure. This passage is marked by entitlement to a few new rights. The 65-year-old can collect Social Security benefits, ride on some public transportation systems at a reduced fare, have some of his medical expenses reimbursed through Medicare, join a local golden age club, purchase a home in certain "retirement colonies," and become involved in the retirees' branch of his labor union or professional association.

Yet the older person must relinquish certain other rights. Society needs and honors a very small number of elder statesmen, wise theologians, emeritus professors, old artists, and mature judges. Self-employed people such as farmers and professionals can choose the timing of their retirement. Otherwise, the older person must give up productive work. His income is cut in half. He has less authority in the family. His word carries less weight with grown children; sometimes, he must accept a position of dependence on them. The older person is also expected to behave in certain passive, dependent ways. If the old person is aged 70 or more, the young watch carefully for those characteristic signs of "slipping" or "senility" which are anticipated in persons of that age. If such signs do not appear—if the old person remains vigorous, active, and alert—they call him "young for his age."

Most of the social changes older people undergo are keyed to chronological age. Throughout our lives, we are confronted with social expectations and patterns based on the number of years we have lived. Even though they may be physically and emotionally prepared, young people are expected to eschew parenthood, creative work, and careers for many years of preparation in school. Young adults can indulge in a certain amount of job-hopping, experimentation, and foolishness. Middle-aged people must show more stability and are given greater power and authority. Older people must relinquish their power and authority. This configuration of rights, responsibilities, and expectations is largely determined by chronological age.

For an older person, this configuration seldom matches the individual's physical and mental capacities. The biological and psychological processes of aging affect individuals at different rates and degrees. Even the most severe biological assaults—such as senile brain disease—occur only in a small proportion of older people, and their effect on behavior cannot be predicted with certainty. Other physical ailments can be controlled by adequate medical care, and their effects limited by the individual's adaptive powers. The old person can sustain a high level of intellectual performance until very late in life. In short, physical and psychological aging is not nearly as uniform as are our social expectations of older people.

The social problems of aging are rooted in this disjunction between the varied individual pace of aging and the more uniform social context within which Americans grow old. Older people face a curious dilemma. Medical science and high living standards give millions of people a healthy old age lasting many years after retirement from adult roles and responsibilities. Yet our society's posture toward this large and capable group of retired people is appropriate only for those who are about to die. The word "society" can seem very abstract, but it means the very concrete world of programs, activities, leadership, work, responsibilities, cares, triumphs, achievements, and failures which make up the fabric of our lives. Older people occupy an uncertain place within this social world. They are gradually excluded from it as they age in years, not necessarily in mind and body.

Most older people make this transition alone, with little preparation. Every other important transition in life—childhood to school, school to job, independence to marriage and parenthood—is marked by social fanfare and accompanied by often lengthy periods of preparation. No fanfare and scarcely any preparation accompany the transition to old age, retirement, and widowhood.

I

DEMOGRAPHIC AND CULTURAL CHANGES

Population Growth

Both the numbers and proportion of older people in the American population have been increasing since records were first kept. However, the increase has been most rapid in this century. In 1900, some 3 million Americans were aged 65 and over; today, the figure is more than 21 million. The proportion of older people in the population has risen from 4 to 10 percent in the same 70 years. Both numbers and percentage of older Americans are still rising. Within the next 50 years, the number of persons aged 65 and over will double to a total of more than 40 million.

The number and percentage of older people aged 75 and over is rising more rapidly than the older population as a whole—indeed, faster than almost any other age group. The 1970 Census found that about one-third of the 21 million American elderly were aged 75 and over. Population projections suggest that by the year 2000, some 28 million Americans will be aged 65 and over, and that 12 million will also be 75 and above.

The unique features of our industrial civilization have created this growing, visible class of older citizens. High quality medical care, improvements in public health, and high living standards have increased life expectancy at birth from 49 years in 1900 to 70 years today. While more Americans are surviving into old age, declining birth rates—another feature of advanced societies—make older people a relatively large *percentage* of the general population. Already, France and several other western European countries have larger percentages of older people than the United States, partly because birth rates in these nations have stabilized earlier than they have in America.

Another sociological factor in the aging of the American population is immigration. Many Americans over 65 today came to this country in the great waves of immigration in the late 19th and early 20th centuries. Many of these now-elderly immigrants are firmly rooted in traditional cultures. However, their linguistic and cultural roots can become barriers when these elderly require social and health services. The foreign-born elderly illustrate another important feature of the older population: the characteristics of this older group are constantly changing. Native-born will replace foreign-born. Those who tend to distrust social services will give way to older people who are politically astute and experienced in obtaining their rights.

One aspect of this trend deserves special notice: women live substantially longer than men. A girl born today has a life expectancy of 74 years, a boy, 67 years. The gap appears to be widening. Some demographers expect older women to outnumber older men 3 to 2 by the year 2000.

Urbanization

While American society has grown older, it has undergone the massive dislocations of urbanization. Only about 40 percent of the American people lived in cities in 1900. Today, that figure is more than 70 percent; by the year 2000, about 90 percent of the population will be living in cities and in the suburban areas surrounding them.

Although older people have become urbanized along with everyone else, the particular details of the process have left them concentrated in certain geographical areas. Older people constitute more than 17 percent of the population in many rural areas of Kansas, Missouri, Nebraska, Iowa, Oklahoma, and Texas, because younger people have left these states for opportunities elsewhere. On the other hand, Florida and California have gained older people through migration. Older people are also overrepresented in the deteriorating central sections of our large cities and in small cities of less than 10,000 population. They are somewhat less concentrated in the booming suburban areas, where more than half the American population lives.

It is unlikely that older Americans ever enjoyed the close kinship ties, status in stable neighborhoods, and authority within an extended family that old people have had in most traditional societies. Contrary to popular myth, the extended family—grandparents, their adult children and grandchildren all living in the same house—was never very common in America. For most of its history, America has been an expanding society. Most old people did not make the westward trek with their pioneering sons and daughters. If they did go, they were not likely to survive the rigors of the frontier for many years. This pattern continues in a different form today as postwar urbanization and mobility disrupt both tightly-knit rural communities and the old urban ethnic neighborhoods created by the waves of immigration. The American norm has clearly become the nuclear family: parents and children living together in a single home or apartment, without grandparents.

Progressive American society also deprives the old person of the one role he has had in most traditional cultures: the role of elder statesman who epitomizes social stability and continuity with the past. A society which treasures the present and the future has little need for someone to embody the past. A culture which epitomizes change and instability has little stability for an older citizen to symbolize anyway. In short, American urbanization has cut away the old person's most natural social role and tends to strip the family of its traditional capacity to support and care for its older members.

Industrialization

Behind our society's urbanization and fluidity are the requirements of an advanced industrial economy. Big factories need big cities. High productivity requires high levels of consumption. Our economy needs large national corporations which can use capital, marketing systems, and skilled workers most effectively on a broad scale.

The logic of retirement, compulsory or otherwise, is rooted in the special needs of an advanced industrial economy like our own. The corporate and governmental managers of our economy must strike a reasonable balance among conflicting forces. The success of our system depends on high rates of employment, high wages, and a stable wage-price structure. Yet it also depends on high rates of productivity which require rapid technological change and low labor costs. Although few claim that compulsory retirement is simply a tool for economic management, it does limit the size of the labor force and keeps wages high. The extended period of schooling for the young has the same effect, although this is thought necessary to supply the high levels of technical skill our economy increasingly requires.

The Pace of Change

All these changes—population growth, urbanization, industrialization, displacement from familiar social roles—are occurring at a remarkably rapid pace. The older person who retires today has seen his society and childhood social values change almost beyond recognition during his working life. He can expect to see them change drastically again during the years he will live in retirement. The pace of change makes his adjustment to old age difficult, and it also complicates society's adjustment to *him*, to his new problems, and to his great and growing numbers.

Furthermore, the pace of change in our society in the postwar period has involved a shift from the older person to the young. American society in the early part of this century was almost completely oriented toward bringing people into the system and keeping them there. Our social institutions strained to accommodate waves of immigrants and rural people and to instill in them skills and competitive spirit necessary for economic and social success. People were brought into the system gradually as they aged. Promotion came slowly; with age, the individual's position generally became more secure and he became more influential. The last part of life was essentially a continuation of the middle years.

Since World War II, much of this emphasis has changed. Retirement has become the norm, as has an extended period of schooling before work. An emphasis on youth and newness has replaced the older stress on continuity and experience. Young people are valued partly because of their superior technical educations, but also simply because they are young. Youth and change have become the name of the economic and cultural game. Meredith Belbin, a student of retirement, comments that "retirement is being used increasingly as a means of getting rid of people in late maturity for one reason or another."

The institution of retirement itself is a creation of the postwar era. For the first time in history, it has become possible for large numbers of people to live without working in a financial condition somewhat more secure than utter destitution. Yet the affluence which makes retirement from the labor force possible has not been accompanied by the creation of new social ro[illegible] for old people. While the termination is not so abrupt as in business, the older person is also less valued in the family, church, neighborhood, and volunteer organizations. Only rarely—as in medicine and law and in certain political roles—is age itself valued for the presumed experience and wisdom of years.

Older people today may occupy that specially exposed position of a social subgroup which has undergone change in advance of the larger society. Older people often experience problems because the larger society does not acknowledge that chronological age is a poor indicator of an individual's ability and status. The majority of retired people are reasonably healthy, alert, and capable—with little call for their talents. Perhaps the enforced leisure of the retired population has influenced the gradual weakening of the work ethic in American society.

These forces—growth in numbers, urbanization, industrialization, the rapid pace of change—largely shape the nature and characteristics of the older population. These forces cut both ways. If they disrupt traditional patterns, they also expand opportunities. Social forces make older people vulnerable and strip them of traditional sources of status and satisfaction. They also give older people a higher standard of living, longer lives, better health, and more options than in the past. The same forces that cause problems in old age also hold out the potential for a vigorous and fulfilling later life.

II

SOCIOECONOMIC CHANGES

Retirement

The phenomenon of retirement is one of the outstanding socioeconomic aspects of aging in American society. Retirement is society's one unambiguous response to the fact that large numbers of its members are living into the sixth and seventh decades of life, well beyond the years of child-rearing and peak capacity for hard physical labor. When the parental role is completed, and the worker enters his 60s, he is expected to "retire." What is less clear is the shape and nature of his life in retirement.

Retirement is also a relatively new idea. For most of man's history, retirement was unknown. A few affluent aristocrats could always pursue their own interests at a leisurely pace; everyone else worked until they became too frail to function or until they died, usually of some disease which is now controlled. With the Industrial Revolution, some wealthy individuals began to acquire enough money to allow them to retire to leisure after a lifetime of work. But until about 1940 in America, retirement was very much a mark of distinction, an option open primarily to the wealthy few. A man or woman who could not work and who lacked family supports lived at the edge of destitution, subsisting on charity or miserably small public welfare payments.

In the past generation, retirement has become a nearly universal experience for Americans who live long enough. About 70 percent of men aged 65 and over are fully retired from the work force; and a good percentage of those still working do so only part-time. While more women over 65 are working than ever before, only about 10 percent are in the labor force. The Social Security Act of 1935 first made widespread retirement possible by providing covered workers with a reliable source of retirement income. In subsequent years, Social Security payments have risen, pension programs have expanded, young workers have pushed for advancement, and economists and employers have grasped the benefits of a small, highly-paid work force. Most importantly, most American employers have adopted the age of 65—the age of full eligibility for benefits under the Social Security Act—as their own standard for mandatory retirement.

The fact that only 3.5 million of the 20 million Americans over age 65 were officially classified as poor in 1974 is a testimony to the strength of the American economy and to the scope of the Social Security program, pension plans, insurance policies, and other programs which provide income in retirement. (The actual number of elderly poor is closer to five million, according to the Senate Special Committee on Aging. The official figures leave out poor old people in institutions, and those living with others in households where combined income is above the poverty level.) Nevertheless, having a job is still the best assurance of an adequate income in the later years. Only 15 percent of the older population work full-time, but their wages account for between a fourth and a third of all the income received by all people over age 65. Older workers in the high-status and high-salaried professional occupations appear to show the least interest in the prospect of retirement.

The majority who retire cite declining health and energy as the main reasons, with employer policy and layoffs falling well behind. On the other hand, American workers seem to be more and more willing to retire voluntarily while their health is still good and they are able to enjoy leisure. The most important factor in a person's decision to retire seems to be assurance of an adequate retirement income. The long-range trend is clearly in the direction of earlier retirement. Labor unions have been successfully negotiating early retirement provisions in their contracts, and many corporate pension plans allow the worker to retire at age 60, or even earlier.

Contrary to popular belief, retirement does not cause declining health. Indeed, declining health more often precedes retirement, and health is just as likely to improve in the early years of retirement as it is to decline further.

The socioeconomic shifts which have produced retirement have also made middle age the older-worker problem age. About 10 percent of the workers between the ages 45 and 64 have been pushed out of the labor force permanently, and about another 10 percent want to work but cannot find a job. These men and women are the victims of discrimination, plant shutdowns, disability, and obsolete skills. Many have been rendered permanently unemployed by the decline of older industries such as railroads, mining, textiles, crafts, steel production, and small businesses.

On the other hand, middle-aged women are streaming into the work force in large numbers. About half of all middle-aged women are in the labor force today—three times what it was at the turn of the century. The proportion of middle-aged women who work is likely to increase as more of them seek higher family income through their own earnings and through entitlement to primary Social Security benefits.

Retirement Roles

Theoretically, retirement opens the door to a host of new activities. In reality, only a small minority of older people seem to reorient their lives in new directions. The majority of retired people spend most of their time visiting, reading, gardening, and watching television. Most people maintain the same pattern of activities they have developed in earlier years.

There are probably several reasons why most people do not take the opportunities that retirement offers. One may be the lack of well-defined social expectations for retired people. In the absence of social roles, many people probably do not know where to turn when they are confronted with a totally free choice of how to spend their lives. Poor health, lack of energy, and limited mobility curtail the options for many retired people, as do insufficient income for food, clothing, bus fares, and membership fees. Finally, a simple desire to disengage from roles, activities, and responsibilities is operative in many old people.

Income

Older people's changing relationship with the economy has been marked by the development of retirement income systems. These include Social Security benefits, government and private pension plans, Supplemental Security Income, veterans' benefits, and private annuities.

While these systems have improved the income position of older people markedly in the past 20 years, an adequate income is still far away for many. For most older people, income drops by about half at retirement, but expenses do not decline by such a large percentage. The main items of retirement expense—food, housing, medical care, and transportation—are precisely the items hardest hit by inflation in recent years. About 80 percent of all retired people receive payments from Social Security or another public program, but these programs in themselves do not provide an income sufficient to live comfortably. The best guarantee of an adequate income in later life is still a job. The next best guarantee is a combination of Social Security and other income sources, such as a private pension, annuity, or income from securities and rents. Only a minority of older people have such resources.

One important implication of this situation is that society will need to provide housing, medical care, nutrition programs, social services, education, and leisure activities for many of the 65 million Americans who will retire during this century. It is not enough to simply give them money, and rely on the market to provide the goods and services they need.

Status

A consideration of the socioeconomic changes with age leads inevitably to a discussion of the changes in status which people undergo as they age. A decade ago, Irving Rosow, a sociologist, described these changes in gloomy terms which still have relevance today.

Rosow said that older people have little basis for a claim for recognition and status in modern society. They have little or no technological expertise, little property except their own homes, no extraordinary religious ties such as older people enjoyed in preliterate societies. They live in anonymous urban communities or are stranded in declining small towns, are experiencing physical and psychological decline, and are not valued in a rapidly changing, future-oriented youth culture. Finally, Rosow notes the absence of a liberal social welfare tradition in America similar to those in Western European nations which provide more adequately for their older populations. The percentage of our national income which goes to Social Security benefits is two-thirds or less of the proportion which several European countries devote to this purpose.

Rosow's case sounds extreme, but it is difficult to fully refute. He raises some questions which uncover basic issues about the social status of older Americans:

—What is the position of older people in advanced societies? What should it be? What values should be attached to retirement?

—Can we open positive, contributing roles for older people? Will the larger society accept these contributions?

—Can a society characterized by rapid advances in knowledge and technological change find ways of integrating into the social mainstream those who have already made their social and economic contributions? How will older people respond to such efforts?

—Will society recognize passive, contemplative, leisure-oriented, and self-expressive roles as worthy roles? If so, what rewards will be attached to them?

—Can urban society provide an environment which will meet the needs of those in the stages of decreasing involvement with life, physical and mental decline, and erosion of middle-aged roles and social contacts? What are the elements in such an environment?

—Will American society catch up with the liberal tradition and allow older people to share in the rising output, greater wealth, modern housing, and the widening range of health, social services, educational, and recreational opportunities?

Movement in this direction demands a high capability for change and adaptation in society. Society, culture, and the economy are comprised of a vast complex of interrelated systems. Change at one point leads to changes at other points. The chain of adaptations to aging seems to have started with urbanization, which has forced older people into dependence on formal organizations—including public and private agencies—as substitutes for the family and neighborly relationships and mutual aid thought to have been characteristic of the village and small town. As change progresses, both the older individual and the institutions he relies on so largely will be required to adapt.

PART II

THE SOCIAL SITUATION OF OLDER PEOPLE

CHAPTER 5

ADJUSTING TO AGING

> What am I good for? I just keep on living. Oh, I'm not a morose man—it isn't a question of that. I have enough money to live decently. My wife is alive and the children come from time to time. I find things to do around the house to keep me busy. But it's not enough. Somehow, it's just not enough. I keep wishing I could do some good—be useful. But I know the answer: it's the end of the road.
>
> —69-year-old retired factory foreman

> I'm Ed Hart and I don't want to be anyone else—I will be the same ten years from now, if I'm alive . . . I have an original motto which I follow: "All things respond to the call of rejoicing; all things gather where life is a song."
>
> —93-year-old ex-rancher

What is "successful" aging? No concept is quite so elusive, but perhaps no question is quite so important to those who work with old people. In terms of the external events in an old person's life, successful aging can seem almost accidental. Like the retired foreman quoted above, some older people have much—family, money, activities, health—and yet have failed to age successfully. Their failure to make some crucial inner change renders them frustrated and unhappy. Others, like the former rancher, achieve an astonishingly successful reconciliation with age, indeed, with life itself. In Ed Hart's case, adjustment had been difficult. When interviewed, he was crippled by disease and nearly blind. He had outlived three wives, both his sons, and all his age peers. He had suffered one nervous breakdown in his 40s. Hart had not been successful as a rancher or, later, as a teacher. By most American standards, Ed Hart had been a failure. Yet for Ed Hart, old age is a delight.

As we use the term, "successful" aging has two major dimensions. The first is the attitude of the older person himself. Does he regard himself positively? Does he think his old age is a success? The second dimension is the judgment of society and others. Do the older person's peers regard him as a success? Obviously, these two dimensions of successful aging overlap and influence each other. The older person's view of himself will be modified by the degree of social success he has achieved. Society's judgment will be tempered by the old person's sense of well-being. Yet the criteria for personal and social success are not perfectly congruent. The essence of "successful" aging is the old person's ability to negotiate an adjustment to tricky and rapidly-changing social terrain.

I

FIVE ADAPTIVE TASKS

What is this social terrain? What adjustments must the old person make to accomplish a successful reconciliation with age?

In their book *Culture and Aging*, Clark and Anderson outline five adaptive tasks which they regard as typical challenges facing the older person. The key to successful adjustment, these authors say, is judicious appraisal of one's strengths and weaknesses, and application of this knowledge to the continued flux of social life. An understanding of these tasks is valuable for everyone who works with older people, or who simply spends time with older friends and relatives. Their contact with old people will be richer if they understand the nature of the adjustments they must make. Thus, we shall briefly discuss the Clark-Anderson model for adjustment to age.

1. *Admit that aging involves limitations*

The old person must first admit that age is bringing limitations to his physical and mental abilities. Subsequent adjustments depend on this admission. The older person cannot begin to alter his personal expectations until he admits that advancing age is limiting his capabilities and that he faces the prospect of relinquishing some of the roles and activities of middle age. Well-adapted old people admit this fact, conserve their energies, and choose their engagements prudently. Poorly-adapted people adopt a variety of strategems to deny that age necessarily brings change.

Two of the most common strategems are denial and sickness. Some old people simply deny that age has brought any change at all. They work harder, hurl themselves into new activities, and try to look younger. Other people admit the reality of physical change but attribute the change to illness. For some, it is easier to be a sick person than an old person. Social pressures also make this choice attractive. It is in many ways less difficult to play the well-defined social role of "invalid" than the more ambiguous role of "old person."

2. *Change physical activities and social roles*

Once the old person perceives the reality of age and accepts its limitations, he must trim down his world to match the facts. The aging executive must delegate more responsibilty to preserve both his stamina and his authority. The aging housewife may have to hire a cleaning woman, get her husband to help with the housework, close off some of the house, or move to a smaller apartment. These adjustments can involve changes in social relationships, financial expenditures, personal goals, and outside commitments. The cause of failure to make such adjustments successfully can lie in one's personality or in exterior circumstances. Clark and

Anderson cite an example of each. The first case is that of Mr. Butler, an unhappy 66-year-old who is simultaneously trying to hold a high school teaching job, study for a real estate license, arrange for the purchase and management of an apartment building, plan investments, stabilize a precarious marital relationship (threatened by his heavy drinking), support a daughter in Switzerland, and maintain active contact with a wide circle of friends. He is failing at most of these tasks. Mr. Butler's overwhelming ambition and inflated aspirations prevent the necessary adjustment of unrealistically wide horizons.

In the second case, Mr. Kreisler, a 63-year-old janitor, is committed to a psychiatric ward after an outburst of violence. Heavy drinking had made his emotional control unstable. In turn, the drinking began when he started to fail to do his job. It turned out that Mr. Kreisler's employer was largely responsible for the breakdown. Instead of helping the aging janitor organize his demanding job properly, he had thoughtlessly assigned him more and more work. Here, the cause of failure lies largely in the aging individual's social circumstances.

3. *Find new ways to fulfill one's needs*

The old person must find new ways to fulfill his physical, emotional, and economic needs when the old patterns change. The man who is retiring must find an adequate income, new friends to replace associates at work, and new activities to give him a sense of accomplishment. The middle-aged woman must "replace" her children, the widow must "replace" her husband. In advanced old age, people must accept some degree of dependence on others and find new ways to feel in control of their lives.

Clark and Anderson found that failure to find new ways to fulfill one's needs is the most frequent cause of maladaption in old age. This is also the adaptive task that depends most heavily on the social system and on other people. The many social obstacles to need-fulfillment in old age include such factors as inadequate sources of income, prejudice against remarriage for widows and widowers, limited mobility, and poorly defined social roles for older people. Thus, it seems easier for older people to change their point of view and ways of thinking than to find other people to help them adapt to aging.

4. *Develop new criteria for self-evaluation*

Old people who are no longer workers, managers, leaders, or active mothers must find new ways to evaluate themselves. They must learn to measure their self-worth by criteria other than success in fulfulling productive roles. This is not easy, because society offers few standards by which older people can measure themselves. This task is largely a personal one. One gerontologist has called retirement a "roleless role."

Those older people who find new criteria for self-evaluation possess a quality that can only be called *relaxation*. They are not as disturbed by difficulties as they once were, and they speak gratefully of their release from the drive to hurry, to compete, to produce. These older people are more tolerant of others and take greater pride in seeing others succeed. They do not experience old age as a downhill slide from maturity, but as a distinct phase of life with its own unique assets and liabilities.

The retired foreman quoted at the beginning of this chapter is a man who is failing to complete this task. Outwardly, he seems to have completed the first three adaptive tasks: he is active, healthy, and has found new ways to fulfill his physical needs. Yet he cannot assign any importance to his life in retirement. Inwardly, he is consumed by the bleakness of his days. He wistfully recalls his job: "I was at the top of the pile . . . I may not have been a mental giant, but the kicks were in knowing that what you did made a *difference*, that you were in there, a part of things."

5. *Establish new values and goals for one's life*

The old person must finally find a place for himself in the larger scheme of things. It is not sufficient for him to preserve self-esteem by becoming relaxed and philosophical. He must find positive acceptance of these values within his social milieu so that his life may be ordered, coherent, and purposeful. To succeed at this task, the old person must cultivate satisfying relationships with other people and achieve positive responses from them. Those older people who exhibit the traits others usually associate with successful aging—wisdom, maturity, humanitarianism, peacefulness, and so on—have not withdrawn from active roles. On the contrary, they are still actively involved in a number of roles, with the difference being that their relationships are less competitive.

Qualities Associated with Adjustment

Clark and Anderson's five adaptive tasks emerged from their in-depth anthropological study of several hundred well-adjusted and poorly-adjusted old people living in the San Francisco area. They observed several qualities which seem to be closely associated with successful adjustment to age.

Attitude Toward Life. Ironically, older people who fail to make a successful adjustment to old age tend to adopt a basic attitude toward life which is usually thought to be essential for social and economic success at earlier ages. Poorly-adjusted elderly tend to be competitive, ambitious, acquisitive, sensitive to social standing, and jealous of personal independence. The well-adjusted tend to adopt a contrary set of values such as conservation, self-acceptance, congeniality, cooperation, consideration, and a modest level of aspiration. Thus, since an aggressive, competitive spirit is pervasive among the young, successful adjustment to aging seems to require an attitudinal shift of major proportions.

Personal Independence. Both well and poorly-adjusted older people rate the ability to provide for their own needs as one of their most strongly held personal aspirations. Yet personal independence means something different to each group, and each pursues this goal in significantly different ways. The well-adjusted elderly want to be independent as a matter of pride and to avoid inconveniencing others, particularly their children. Said one old woman: "I hope to stay healthy, care for myself, and hope my children are happy and healthy. To be independent, that's what I want to keep. If you can be happy and enjoy life all the time, others around you will do the same." At the same time, well-adjusted old people are aware that total independence is foolish. They want the security of knowing that they can call on someone for help when they need it.

On the other hand, poorly-adjusted old people tend to desire independence for defensive reasons. They often fear and mistrust their families and friends, and speak of negative experiences they have had with others.

Their desire for independence is motivated more by fear of dependence than by pride in autonomy. Said one man: "I don't go to anybody with my problems; I just work it out. I never care about what the other fellow does, and he don't care about me."

Social Acceptance. A similar dichotomy emerges in old people's pursuit of social acceptability, another important goal. The well-adjusted old person tries to achieve social acceptance through congeniality and by simply being an interesting person for others to be with. One woman likes "to give a lift to people. I like to praise people. We don't do enough of it." Maladjusted older people tend to seek acceptance through achievement, talent, and by a claim to superiority. They believe that others do not respond to warmth and happiness, but only to strength and power. An old woman, recently released from a psychiatric clinic, believes that the most admirable person is "one that is up and moving, contributing something to society, accomplishing something on his own—and one who would make good and not make excuses. . . Anyone who is educated and ambitious is easy to get along with, but the incompetent and uneducated cause all the trouble in the world."

Resilience. Well and poorly-adjusted older people cope with external threats in their characteristically different ways. Well-adjusted individuals will demonstrate resilience in the face of illness, death, loss, and the other deprivations of age. They seem able to distinguish between situations which can be changed and those which cannot. They can act resourcefully to change unpleasant but alterable circumstances, while demonstrating flexibility in the face of situations which they cannot change. The attitude underlying this resilience is a basic acceptance of life, a realization that men, especially old men, are not entirely the masters of their fate.

Poorly-adjusted people, on the other hand, seem to regard acceptance as a personal defeat. They are compelled to *do* something about every difficulty that comes up. Yet they are crippled by an inability to distinguish between changeable and unchangeable circumstances. Clark and Anderson cite a former mental patient, now living alone, who almost caricatures a primary American cultural value which, in this case, serves an old man badly:

> The best way of getting along in life is doing things to help yourself. There are hundreds of persons not deserving, because they go against the laws of nature. God helps those who help themselves. Pick yourself up—how does that song go? Pick yourself up, brush yourself off, start all over again. Always try, try again. The more people tell me I can't do something, the harder I try to prove I can. That's me all over.

Clearly, old men and women who approach life with good old-fashioned aggression meet many situations which they cannot control.

Patience. Adjustment to aging takes time. Clark and Anderson found that old people in their 70s were better adjusted than those in their 60s. Men seem to adjust more easily than women, possibly because most old men are still married and demand less from their relationships with their children than their wives do. For both men and women, however, the greatest problem in adjustment is finding new ways to fulfill their needs. Men have the greatest difficulty replacing the satisfaction of work; women have the most trouble relating to their children and coping with widowhood. Poor health and poverty can make the individual's effort to adjust a nearly impossible task.

Adjustment and Theories of Aging

Neither of the two major theories of aging—disengagement theory and activity theory—provides an adequate model to explain successful adjustment. Disengagement theory, which holds that a satisfying old age involves a withdrawal from the normal activities and responsibilities of middle age, oversimplifies the inner meaning of older people's actual behavior. On the one hand, many well-adjusted old people cherish their wide range of social contacts and will do anything they can to replace associates and friends they lose through death, retirement, and illness. On the other hand, many poorly-adjusted and unhappy old people are disengaged, often to the point of complete isolation. While successful aging does involve a measure of disengagement, withdrawal from activities can also happen because the old person is apathetic, suspicious, and depressed. One intensive study of several hundred poorly-adjusted old people living in a community found that none of them had a single close relationship with anyone.

Activity theory, which states that the key to successful aging is maintaining a middle-aged level of activity as long as possible, is similarly deficient. Obsessive, hyperactive involvement can be a characteristic of poor adjustment at any age. Some degree of disengagement in later life is desirable as physical powers decline.

This idea of adjustment presented in the five adaptive tasks is drawn from a life cycle view of development. It sees old age not as a continuation of middle age, but as a definite stage of life with its own unique challenges and rewards. The individual enters old age as a person shaped by his past life. The old man remains the man he has always been, with his characteristic preferences, habits, and personality. Disengagement theory and activity theory suggest that adjustment to old age can go in only one direction. The life cycle view holds that adjustment can go in many directions, and that persons of many different personalities can effect a successful adjustment to old age in many different ways. In fact the most successful older people Clark and Anderson found were those who had learned to engage and disengage continually, in a rhythm that suited their desires and circumstances. Adjustment to aging resembles a universal pattern of life—work followed by rest, periods of solitude and contentment followed by restless searching and activity.

II
PERSONALITY IN LATER LIFE

The factor that influences the older person's adjustment to aging most heavily is his personality. Personality is the individual's characteristic way of perceiving and dealing with the events of life. It mediates among outward events and inner changes, inner response and overt behavior. Personality has both inner and outer dimensions. The inner dimension includes one's self-concept, moods, values, reactions to people and events, and judgments about what is important. Outward personality is the face one presents to the world: cheerful, cranky, gregarious, open, apathetic, self-controlled, breezy, rigid. The inner and outer dimensions of personality overlap and influence each other, but the congruence is only partial. Indeed, a test of a "successful" personality is the capacity to resolve conflict between the inner response and overt behavior. An individual of any age who says precisely what is on his mind and who acts precisely according to his feelings is successful only in an extraordinarily tolerant environment.

While gerontologists know that personality plays a central role in the older person's process of adjustment, they have only begun to systematically study the actual operation of personality in later life. The study of personality involves formidible methodological problems. Investigators are forced to make risky generalizations about the unique "styles" of millions of individuals. They tend to employ complex concepts and an esoteric technical vocabulary. Since many approaches have been used to study the human personality, it is difficult to present a unified picture of our knowledge.

The picture we shall present briefly here is a developmental approach used by Bernice Neugarten and her colleagues, the team that has done the best work in the study of personality and aging. The developmental approach sees personality not as a fixed entity, but as a dynamic system that continually changes in response to inner and external changes. The Neugarten studies of adult personality add up to a relatively complex picture, one with significant implications for the process of adjustment.

1. *Old people show a variety of personality styles as they make or fail to make adjustments with advancing age.* Neugarten and her associates have identified eight distinct personality types among a group of 70- to 79-year-olds living in the community and carrying out a normal round of daily activities. Some of these individuals easily slough off various role responsibilities and remain highly content with life. Others limit their activities and become less satisfied with life. The names these investigators attached to the eight personality types convey some of the flavor of the style of aging they represent: Reorganizer, Focused, Disengaged, Holding-On, Constricted, Succorance Seeking, Apathetic, and Disorganized.

2. *Personality type is the key factor in predicting which individuals will age successfully.* Although they lack long-term data to fully confirm it, investigators feel that personality patterns in later life reflect long-standing life styles which have been characteristic of the individual for many years. Within broad limits, barring major severe illness or social catastrophe, patterns of aging are predictable from observing the individual's personality style in middle age. Thus, in adapting to physical and social changes, the aging person will draw upon the resources he has accumulated over his lifetime. His outward style of coping with change is likely to be consistent.

3. *Personality change with advancing age tends to involve greater preoccupation with the inner life.* For example, Neugarten's studies show that 40-year-olds perceive the social environment as one which rewards boldness and risk-taking, while 60-year-olds see the world as complex and dangerous. Age appears to bring a reduced readiness to relate emotionally with other people, to behave in assertive ways, and to face challenges. At the same time, the old person tends to become more preoccupied with fulfilling personal needs.

4. *This shift from an active to a passive stance takes different forms in men and women.* Men appear to cope with the environment in increasingly

abstract terms. Children, grandchildren, relatives, and friends may find the older man less warm, more detached, less involved emotionally. On the other hand, women tend to indulge emotional and egocentric impulses with advancing age. In contrast to men, women may seem less inhibited, more expressive and emotional. However, both styles appear to be expressions of the growing preoccupation with personal needs and the inner life that is characteristic of aging people.

5. *This preoccupation with the inner life does not appear to affect older people's outward style of adaptation to changes and challenges with age.* Neugarten and her associates find an apparent paradox: a definite shift toward passivity and inner preoccupation comes in later life, to the point where many old people exhibit patterns of thought and feeling that would be termed "pathological" in younger people. Yet most old people continue to function in stable and consistent ways. The inner shift does not have the outward effect it should have.

Neugarten concludes that the paradox may be explained by the extreme stability of outward patterns of coping with the social environment. The old person's "self" becomes an institution, buttressed by familiar and habitual networks of social relationships and patterns of interaction. It seems that the older person decides, "this is the type of person I am. I'll never change." Perhaps the rigidity so often attributed to old people is simply an extremely consistent way of looking at things.

The general direction of these studies of personality serves to further deemphasize the importance of chronological age as a factor in adjustment. Since personality types remain very stable and since old people grow old in many different ways, the social and cultural environment which the elderly inhabit takes on new importance. The implication of these studies is that such factors as work status, health, financial resources, and marital status are more decisive than chronological age in influencing the degrees of adjustment older people are able to make.

III
ATTITUDES TOWARD AGING

A key aspect of successful adjustment in later life involves attitudes toward aging, especially the older person's attitudes toward his own condition and younger people's attitudes toward the old. Do older people feel honored when the young refer to them as "senior citizens?" Do they believe they are living in the "golden years?" Do young people believe these phrases as they utter them? Or do old and young interact with each other on a different level?

The eighteenth-century British critic Samuel Johnson thought they did. He once complained to his biographer Boswell, "There is a wicked inclination in most people to suppose an old man decayed in his intellects. If a young man or a middle-aged man, when leaving a company, does not recollect where he laid his hat, it is nothing; but if the same inattention is discovered in an old man, people will shrug their shoulders and say, 'his memory is going.'"

"People expect the worst for us," wrote the French novelist Francois Mauriac in his old age. "If your hand trembles as you put down your coffee cup, the trembling is noticed. Even the way they say how well we look saddens us profoundly. People exclaim at an old man's youthful appearance; whereas it would never enter their minds to try to persuade a hunchback that his spine is straighter than it seems."

Mauriac's division of humanity into us (the old) and them (the young) appears to accurately reflect the way old people look at things. Old people tend to be very sensitive to what young people think of them. They pay special attention to the responses and signals they receive from others. They do so for one very good reason: older people cannot measure the pace of their own aging any other way. Aging is a very gradual process. It can progress unnoticed until one discovers that one's hand *is* trembling at the dinner table, and that others notice it as well. The reality of age is communicated to the old through the responses of the young: the looks, the smiles, the hearty reassurances, the ambiguous conversational subtleties, the gradual pressure and the well-meaning advice to "act old." In other words, *a man becomes old when others decide he is old.*

Social scientists have accumulated a mountain of data about the operation of this crucial interplay of attitude and response among the old and the young. As in many areas of scientific investigation, the existing data in many ways serves only to highlight how little we actually know about the problem. For example, we do not know how or if attitudes toward age change as people grow older. Nor do we know whether attitudes toward age in the United States differ from those in other cultures. Neither are social scientists willing to claim that certain circumstances of old age produce certain negative attitudes, or that certain negative attitudes clearly hamper older people's adjustment to age. Nevertheless, a number of useful conclusions about attitudes seem to emerge from the data.

In general, old people in the United States seem to hold negative views toward aging, themselves, and toward life in general. They share these negative views with the young, although it appears that old people are no more or less gloomy about age than are young people. The studies also show that it is impossible to separate an abstraction called "age" from the socioeconomic circumstances of being old. Isolated, inactive, ill, and institutionalized old people are far more likely to hold pessimistic views toward "age" and to have a low morale. Sadly, many of older people's negative views of aging seem based in reality.

The studies reveal an intriguing interplay between old and young. Old people tend to claim that age does not affect their *personal* relationships with young people. Yet they hold much grimmer views when asked to *generalize* about young people's attitudes toward the old. Clark and Anderson found that half of their group of both mentally ill and mentally healthy old people mentioned *only* negative attitudes when asked to generalize about the views of the young. They suspected that young people thought the old were backward, old-fashioned, and mentally inferior. At best, the young were simply indifferent to the old. "I hear them [young people] talk," said one old man. "They say 'Oh, an old crowd goes there; let's not go.'"

However, old people are hardly indifferent to what the young think about them. They are sensitive about being considered different, set apart, or rejected. This sensitivity was measured by Kogan and Shelton, who asked groups of young and old people to complete sentences describing the elderly. To complete the sentence, "In general, older people need . . ."

young people answered "assistance" or "help." Old people more often replied, "positive response from others." Other replies suggested an atmosphere of cross-generational conflict. To complete the sentence, "Old people tend to resent . . .", young people chose the answer "younger people." Old people were much more specific. They resented "rejection," "lack of concern," and "reference to age." Young people said they would remain indifferent to a strange old person who sat next to them on a train or bus. Old people said they would be much more interested in the stranger.

Old people seem to anticipate this indifference or hostility, and are willing to behave differently in order to achieve positive response from the young. The sentence completion test showed that old people are extremely sensitive to their personal appearance, and worry about how they look to young people. Ironically, young people seem indifferent to the appearance of the old, and do not notice their efforts to look neat.

The data seems to support Clark and Anderson's conclusion that old people relate to the young ambivalently. The old make serious efforts to elicit a positive response from the young, and indeed claim that their personal relationships are amiable and satisfying. Yet old people know they are excluded from social and economic life. It is an exclusion imposed by the young. Thus, beyond personal contact, relations between young and old are marked by indifference, even hostility. This ambivalence is strikingly similar to relationships between minority groups and dominant whites. Like blacks and whites, the old and the young generally try to be personally agreeable to each other. Yet the overall social context is marked by detachment and indifference.

In her old age, Florida Scott-Maxwell, a psychologist, summed up this attitude well. She said, "What we get is an odd experience of anonymity, as though we moved along the cracks between the lives of other people." This remark recalls the emotions of the black man in the white culture, described memorably in Ralph Ellison's *The Invisible Man*. Yet Dr. Scott-Maxwell thought this feeling of invisibility had its compensations. "No longer greatly impressed by humanity, no longer sure they themselves exist, feeling it hardly matters if they do, [old people] gain a new ease in remaining as uncovered and limpid as children."

CHAPTER 6

ADJUSTING TO RETIREMENT

Most men meet their first and often greatest challenge of older age when they retire from work. The same is true for many women. Because of their employment in increasing numbers, more women will undoubtedly face this challenge in the future. The older worker must first decide when to retire—if he has a choice—and then adjust to the unfamilar role of leisure which retired Americans occupy. The tasks of adjustment involved in retirement are complex. The older person's ability to accomplish these tasks frequently determines his success in adjusting to old age. It often determines his spouse's success as well.

I
THE DECISION TO RETIRE

The majority of retired workers—two-thirds or more of the total—claim that they made their own decision about retirement. In view of the social and economic importance of work in America, this decision is a crucial one. The individual must rethink the value of work in his life, give careful consideration to his health, make often complicated and long-range financial provisions for his years of living without working, and prepare to adjust to leisure activities. The retirement decision is a challenge to society as well as to the individual. Social institutions must also adjust to the growing numbers of retirees and find ways to help them make the transition from work to leisure.

In the past decade, more workers have been voluntarily choosing to retire prior to reaching age 65. Some 53 percent of the retirees in 1966 retired early; the percentage is probably higher today, although inflation forces many workers to stay on the job as long as possible. The trend toward early retirement seems to underscore a weakening of the traditional ties that have bound Americans so closely to their jobs. While early retirement has usually been associated with severe health problems or chronic unemployment, today more workers than ever before are retiring because they prefer leisure to working. Moreover, a larger percentage of younger people than ever before say they plan to retire early. It seems that in the future there will be many more retirees, a significant proportion of them younger men and women.

A close look at the factors that influence the retirement decision suggests how complicated this matter really is. For the individual, it involves intertwined choices. Different groups of Americans approach the decision in widely varying ways.

When asked directly why they chose to retire when they did, a sample of voluntarily retired workers listed the reasons in this order: health (nearly 50 percent), desire to spend more time with the family, inability to get or retain a good job, and financial ability to retire. Of the 30 to 35 percent who report they were forced to retire, most reached a mandatory retirement age, while others were told to retire because of poor health, were laid off, or lost their jobs when plants closed down. Compared to other industrialized countries, America has a very large number of old people who retired simply because they could afford to.

A 1966 study showed that workers who could look forward to retirement income of over $4,000 a year were much more likely to have plans to retire early. (Of course, a similar figure today must be adjusted substantially upward to accommodate inflation.) Other financial matters also proved to be crucial to the retirement decision. These included the number of dependents the worker expected to have after age 60, and whether he would need to make mortgage payments on a home. Ironically, those who could look forward to financial security were also those who made the most careful and extensive preparations for retirement. Those who did not have good pensions—presumably the workers who have the greatest need for preparation—prepared for their retirement the least.

To sum up, finances are the most important factor in the retirement decision. Once a person can afford to retire, other factors such as health and desire for leisure will influence the "timing" of retirement. If an individual cannot afford to retire, only serious illness or an economic disaster like a plant closing is likely to separate him from the labor force before he reaches a compulsory retirement age. The fact that most retired men cite poor health as a more important factor than financial security needs to be understood in this context. "Poor health" frequently means an inability or unwillingness to put up with the tedium and physical demands of blue collar and low-level white collar jobs. It is gladly seized as the reason for retirement if the worker has the money to do so. Poor health is less frequently cited as a reason for leaving demanding but challenging professional, technical, sales, and managerial occupations.

Approximately 15 percent of those in the labor force plan to retire late. This includes individuals who plan to retire past age 69, who intend to keep working as long as possible, or who say they will "never" retire. The late retirees are concentrated on the upper and lower ends of the income scale. They include highly-paid professional people who derive much personal satisfaction from their work, and unskilled poor people who must keep working merely to survive. Large numbers of minority group elderly are in the latter category. Very often, they cannot even look forward to Social Security benefits. Farm labor and domestic work—two occupations which have traditionally employed sizeable numbers of minority group workers—have only recently been brought into the Social Security system.

Constraints

Although Americans are enjoying greater flexibility in their decisions to retire, their choices are still restricted by a number of constraints. Most older people, at least those who have participated in such forums as the 1971 White House Conference on Aging, would like to see these constraints removed. Gerontologists who are concerned about the well-being of older people, and economists who are concerned with the most effective utilization of the labor force, agree that maximum flexibility in the retirement decision is a worthwhile social goal.

The first constraint is the employment problem among middle-aged workers. For a variety of reasons, workers above age 45 have difficulty remaining in the work force and retaining a high level of skill to keep up with rapid technological change. Perhaps 15 percent of all workers aged 45 and over are unemployed at any one time. For many, early retirement means permanent unemployment. Along with technological change, factors contributing to this situation are the unwillingness of older workers to relocate, concentration of older workers in dying industries such as railroad transportation, and age discrimination in employment.

The greatest constraint on retirement flexibility is the compulsory retirement age, a reality which exerts subtle effects on everyone in the labor force. While only 20 percent of older workers retire because they reach the mandatory age, those who retire earlier must make their plans in light of the upcoming deadline of 65 or 70. In general, those who retire before 65 retire "early;" those who leave their jobs afterwards retire "late." The compulsory retirement age of 65 is largely a creation of the Social Security system which, in 1935, established 65 as the minimum age for receiving full retirement benefits. Thousands of businesses have adopted 65 as their own mandatory retirement age. Although data on the subject is incomplete, at least two-thirds of all private employers demand retirement at 65, regardless of the individual's ability to handle assigned work satisfactorily. The effects of this requirement have been dramatic. Male labor force participation drops from about 90 percent from ages 55-59, to about 80 percent for ages 60-64, to about 35 percent for ages 65-69.

This compulsory retirement trend is bolstered by subtle and overt pressure on older workers to leave their jobs. Again, data is hard to come by, but there are indications that both employers and unions are interested in getting older workers out of the labor force. Employers feel that younger workers are more capable, and unions want older workers out so their younger members can move up in seniority. A recent study found that about 20 percent of employers directly encouraged retirement prior to age 65. A majority of employers were officially neutral, but nevertheless encouraged early retirement through financial incentives, mainly in the form of supplemental pension benefits until full Social Security benefits take effect at age 65. Much of this attitude is directly attributable to simple discrimination: young is more desirable than old. It is also a way of reducing the size of the work force, particularly in the hard-pressed, dying industries where older workers tend to be concentrated.

A final important constraint on work force participation among older people is the Social Security retirement test. An eligible retiree's benefits are reduced $1 for every $2 of earnings over $2,400 a year. However, he will receive benefits every month in which he does not work, regardless of his total annual earnings.

Preparation

Most older workers have made only minimal and usually informal plans for retirement. According to studies, the most common preparation for retirement consists of conversation with one's spouse and children, plus a simple examination of the income one can expect from Social Security and pension plans. Even the most sophisticated older workers seldom make extensive plans to adjust to the effect of retirement on health, personal life, and leisure activities.

Nevertheless, a significant and slowly growing number of older workers now have the opportunity to attend some kind of pre-retirement preparation program. Some programs are offered through local adult classes, but most are supervised and staffed by employers and unions. At present, considerably less than half of American companies make any attempt to prepare their employees for retirement; probably less than 10 percent of these offer intensive "comprehensive" programs which discuss problems of adjustment, use of leisure time, physical and mental health care, and other non-financial matters. Since most programs concentrate almost entirely on financial aspects of retirement, firms with poor pension plans tend to avoid pre-retirement programs. Pre-retirement programs are much more common in the East and Midwest than in the South and West. More than half of these programs are less than five years old. The typical corporate program is a group class offered to older workers who are close to retirement.

While there is little evidence to prove a direct connection between pre-retirement preparation programs and successful retirement, most employers offering such programs and employees participating have positive attitudes toward them. Even workers who have already retired say they find these programs useful. However, most workers who complete such programs are probably predisposed to like them; attendance is voluntary and the sessions are almost always held on company time. Also, those who enroll tend to be workers who are looking forward to retirement and have already done substantial preparation on their own.

Employers usually report that preparation helps retirees to adjust, weakens resistance to retirement among older workers, and contributes to an overall improvement in morale and job attitudes. The companies that offer preparation programs generally feel that it is the responsibility of business to help "re-program" the worker from a work orientation to a leisure orientation. On the other hand, many companies feel that retirement is an individual responsibility and that government, not private enterprise, has the responsibility to solve the problems it brings.

II
THE EXPERIENCE OF RETIREMENT

Prepared or not, most older workers leave their jobs by about age 65 and spend the rest of their lives in retirement. It is difficult to generalize about how retired Americans experience this state. Some—those who have derived their principal satisfaction and identity from work—are devastated by enforced leisure. Others are relieved at the chance to leave their jobs and do nothing. Some seize retirement as an opportunity to develop new, creative interests. For most, retirement is a process, with retirees and their spouses experiencing the state differently at different points in time. Despite the overpowering diversity of the retirement experience, what follows is an attempt to make some helpful generalizations about it. Retirement itself is one of the few experiences that most older people—at least those who once had jobs—have in common.

At any one time, a majority of older people probably would say they experience retirement in one of two ways: either as a state of unsatisfying idleness which they resent, or as an enjoyable respite from a lifetime of work. The majority seem to accept it; most workers retire voluntarily, and at least a third of these do so precisely to devote more time to leisure. Given assurance of an adequate retirement income, most older workers would probably gladly retire, even if they have been highly competitve work-oriented people. Another important factor in successful adjustment to retirement is the presence of retired friends to help make full-time leisure an acceptable way of life.

A smaller number of retirees never manage to find sufficient rewards in leisure to replace the satisfactions they had from work. They do not feel justified in deriving satisfaction from leisure because they have never perceived leisure as a legitimate way to spend one's time. These individuals retire involuntarily and reluctantly, and, not surprisingly, quickly become bored and discontented. Many of these retirees eventually withdraw into a disgruntled apathy.

This latter image of retirement is rather widely held among the young. Active, competitive, success-oriented young people feel that retirement *must* be traumatic because it so directly violates the doctrine of the American work ethic. There is a certain amount of truth to this view; probably few older workers retire with perfect aplomb, entirely free of tension between their new state of leisure and the memory of the satisfactions and habits of four or five decades of work. The urbanization and industrialization of our society has largely separated man's work from his family and community. The identity an adult has historically had as a member of a viable community he now receives from his career. The wage system has replaced the economic function of the family and community. A man's work replaces his old links to the traditional political and family systems. Severing that key link to work must be traumatic, for work has isolated man and made his relationship to society an individualistic one.

However, at the same time, retirement has been established as a *right* for all workers. In 1935, the Social Security system established a right to a retirement income, and in succeeding years the popular view has grown that workers deserve a period of leisure after years of productive contribution to the economy.

To sum up, retirement is an ambiguous, problematic institution which Americans can justifiably experience and perceive in many ways. The view that older workers deserve leisure—at least partly at public expense—after a lifetime of work is a widely-held popular belief. However, retirement also contains the suggestion that the older worker has grown incompetent, cannot meet the demands of competitive industry, and should be eased out when his most productive years are over.

Whatever the underlying rationale for retirement, most investigators of the matter think that most workers are not particularly troubled by the suggestion that they are obsolete. The adjustment problems sometimes associated with retirement stem from the loss of work identity only in a minority of cases. In fact, a highly positive orientation toward work does not seem to affect adjustment to retirement. The reluctant worker at a dreary, dirty assembly line job and the competitive, successful executive are equally likely to flourish or wither in retirement.

Two social trends seem to be helping to encourage a positive view of retirement. First, retirement is increasingly perceived as a normal part of the life cycle, and is gaining social acceptance. It has become an experience that nearly everyone shares and thus can hardly be stigmatized. Second, the strict, hard-line work ethic is rapidly becoming antiquated. Perhaps we are coming full circle as many younger Americans choose to restore their links to community and family at the expense of a competitive, mobile, successful career. Or, more accurately, those who choose family and community are not restoring the past, but are creating an America that never was.

Leisure

Old people in Denmark, Great Britain, and other European countries view retirement as essentially a time of rest. Perhaps typically, Americans speak of retirement in terms of leisure *activity*. Retired people in this country feel they must be *doing* things. Even passive leisure activities are seen as opportunities to accomplish something or to improve oneself. For example, retired people prefer "serious" content in their TV shows, such as documentaries and news programs. They tend to give lower ratings to entertainment shows, and movie-going drops off rapidly after age 50.

In general, however, the leisure activities of older Americans do not reflect great enthusiasm for the cultural opportunities of a leisure society. The most popular leisure pursuit for older people—as for all Americans of all ages—is watching television. On the average, retired people spend just under three hours a day in front of the tube. The next most frequent activities are visiting, reading, gardening, walking, and handiwork. Older people also spend some time just sitting, but pure idleness is not really common until very advanced ages. Older people do not frequently engage in creative activities such as listening to serious music, painting, sculpting, or writing. Neither do they attend concerts or plays in great numbers.

In fact, patterns of leisure tend to remain extremely stable over the life span. While people will drop some interests, such as participation in sports, as they grow older, most retired people do the same things for relaxation that they have done all their lives. Significant changes toward more effective use of leisure time will probably come slowly, as younger people learn the skills necessary for more creative activities. Whether this is happening yet is questionable. Social critics observe that mass higher education, including widespread exposure to liberal arts education, has not led to a wider range of leisure pursuits. College graduates and those with little education tend to pursue the same activities for relaxation—television foremost among them. Our educational system is still primarily oriented toward preparing young people to fill instrumental work roles, not to showing them how to enjoy themselves while not working. As the editor Norman Cousins puts it, "Science tends to lengthen life and education tends to shorten it . . . education has the effect of deflecting men from the enjoyment of living."

Education in Later Life

Education is the traditional mechanism for personal adjustment to social change within our society. Formal education socializes the young person and gives him the skills and credentials he needs to participate in economic and social life. After formal schooling is completed, the individual usually faces a continuous series of workshops, seminars, orientation programs, and other short-term training sessions designed to keep him on top of change. Even for relaxation, many thousands of adults take a course—at a university or community college, at an evening adult school, at a YM or YWCA, a church, or other setting. In short, education is rapidly becoming a way of life. Learning must be as continuous as change itself and inevitably life-long in character.

One can scarcely exaggerate the scope and implications of this new mandate for the educational enterprise. For older people, its importance is even more urgent and far-reaching. Not only must older people cope with the same social and technological change as does everyone else, but they must also adjust to the unique changes that come in the later part of life, including retirement, leisure activities, widowhood, chronic illness, and eventual dependency. It would seem that learning opportunities for older people should not only be extensive, but should also assume a character quite different from education for other age groups.

However, education in America is still largely the preserve of the young. The harshest assessment is that educational opportunities for older people are exceedingly scarce and are available only to a middle class and upper middle class elite of the elderly. A more optimistic view holds that the formal and informal systems which can meet the educational needs of older people show all the ambiguity, promise and unevenness of something in the early stages of growth. Nevertheless, the current state of learning opportunities in the later years is discouraging. Howard McClusky, professor of education at The University of Michigan, calls adult education a stepchild of the educational and gerontological establishments. Education for aging, he says, "is an orphan living in the attic of the stepchild's home."

The available statistics bear out McClusky's view. The vast growth of the educational establishment has left older people largely untouched. Participation in all types of educational activities declines after age 50 and drops sharply after age 65. Only 3 percent of all those enrolled in adult basic education programs are aged 65 and over. This figure is especially distressing because the low level of formal education among older people makes them the group which probably needs adult basic education the most. For example, the average person aged 69 years old today discontinued his schooling in 1919 after the eighth grade. How does the instruction received between 1911 and 1919 equip him or her to face the world of the 1970s?

Why do so few older people participate in educational activities? A major reason is simply the disheartening social and economic circumstances of being old in America. For many millions of older people, life is an unrelenting struggle to remain healthy, financially solvent, and secure. This effort leaves little time and energy to pursue educational objectives.

Another reason for minimal participation is failure of "educational nerve." Many older people have serious doubts about their ability to learn, and are unwilling to expose themselves to learning situations where they might fail. This fear is much more mythical than real. All available data about intelligence changes over the life span suggests that age *per se* is no barrier to learning. Older people tend to learn more slowly, but no less certainly, than young people. Educators like McClusky claim that older people gain in experience what they may have lost in speed in a learning situation. Nevertheless, the feeling that new learning is a futile enterprise is widely held among young people as well as old.

A final difficulty is the relative isolation of the older population. Older people are essentially "hidden" in our culture. They live on the fringes of the usual channels of communication—including those channels which publicize educational opportunities for adults and which place such stress on continued learning.

A large share of the responsibility for reaching, recruiting, and involving older people in educational activities is lodged with the educational establishment itself. Organized efforts to develop policy and programs in education for aging are practically nonexistent. No office of the federal government takes an interest in the matter; only one state department of public instruction—New York's—has a unit devoted to education for older people.

Meanwhile, the most promising areas of growth appear to be community colleges and other community-based institutions such as churches and synagogues, YM and YWCAs, libraries, museums, and senior centers. Most older people who do participate in educational activities do so through these informal systems, although the total number is still very low.

Programs

The most imaginative and successful of the programs designed to help older people to employ their time well are those that recruit retirees for service to others. Among these are RSVP (Retired Senior Volunteer Program), on a national basis, and Project SERVE (Serve and Enrich Retirement by Volunteer Experience), operating mainly in New York State. Such programs place older volunteers in a variety of settings such as state hospitals, children's homes, and public and private social agencies. The directors of the projects stress flexibility and ingenuity in learning new roles. They have developed explicit guidelines for recruiting, training, and follow-up.

The Foster Grandparents program has successfully employed thousands of low-income elderly to work with children in state hospitals and other child-serving institutions. The program is based on the observation that young children and older adults benefit from sustained and affectionate contact with each other.

The Senior Companion program, initiated in June 1974, is patterned after the Foster Grandparents program. It will enable low-income older persons to help meet special needs of adults, particularly the elderly who reside in their own homes, in nursing homes, or in other institutions.

Senior citizen centers are another major contribution to the development of new roles in retirement. In the 30 years since the senior center "movement" began in New York City, centers have appeared in every sizeable city and have broadened their focus from simple recreation to educational and cultural pursuits. The typical center offers several recreational programs, plus one or two community service or counseling programs.

Other programs which involve retired people in aiding others include the Service Corps of Retired Executives (SCORE) and the International Executives Service Corps, both of which use retired executives to help small businessmen; VISTA, which brings older people to work in poverty areas; the Teacher Corps, which uses retired teachers to help disadvantaged children; and Operation Green Thumb and Green Light, which employ low-income rural elderly.

CHAPTER 7

OLDER PEOPLE IN THE COMMUNITY

Older people play distinct and important roles in the American social system. They are husbands and wives, brothers and sisters, parents and grandparents, friends, voters, neighbors, churchgoers, and members of local and national organizations which wield political and social influence. Older people live their lives, find their satisfactions, confront and try to solve their problems as social beings in social settings. In this chapter, we shall examine older people in some of these major social roles. The chapter concludes with a brief discussion of some issues in providing social services for the elderly.

I

MARITAL STATUS

Most older people are married and live with their spouses in their own households. Less than ten percent have never married and about two percent are divorced. But even though the older population is dominated by married couples, about half of all women aged 65 and over are widows. Only 20 percent of the men are widowers. This picture of marital status among future generations of old people should remain basically unchanged. Slightly fewer old people seem to be living their entire lives without marrying at all. At the same time, divorce is becoming more common and the percentage of divorced elderly will rise. However, death rates are higher for divorced people, partially offsetting the expected increase in the number of divorced elderly. Widowhood is inevitable for one partner in each marriage, but better health care and higher living standards will postpone it until later in life.

Married Elderly

Marriage is the focal point of the lives of that majority of older people who have a living spouse, especially as retirement and the departure of children limit other relationships. Most older people appear to be happily married; at least they are less likely than younger people to say that their marriages are troubled.

The happiest marriages in old age appear to be characterized by a greater equality between the partners than is the case with unhappily married couples. Clark and Anderson observe that, "Rather than the feminine subordination to a husband, husband and wife appear more as social equals, dividing up the labor of the household, blending the masculine and feminine into one tight little social unit." In other words, successful marriages in later life appear to stress what sociologists term the "expressive" rather than the "instrumental" functions of marriage. Instrumental roles are those which simply get the necessary work done in marriage. Under the traditional division of instrumental roles, the man is economic provider, and the woman cooks, cleans, and takes care of the children. The most successful marriages in later life seem to be those where the partners succeed in replacing these instrumental roles with "expressive" functions of loving and caring for each other and sharing the work. Such adjustments seem necessary, for retirement and the departure of children from the home strip the older husband and wife of their instrumental roles. Husbands in these mature marriages are particularly likely to view their wives as indispensable pillars of strength. The greatest fear for both husbands and wives in the happier marriages is the dismal prospect of widowhood.

However, many older couples also live together unhappily. Religious strictures and social pressure keep couples together who would otherwise be divorced. The weakness of these marriages often becomes apparent when a resented spouse falls ill and requires a great deal of care from the other partner. The strain of this situation is often intolerable. Again, unhappy older marriages are characterized by neglect of the expressive functions of love and understanding.

Most older people who marry or remarry in later life do so to find companionship. Other elderly people marry to escape dependency on their children, or to obtain a partner who will care for them if they fall ill. Most late marriages and remarriages appear to be genuinely successful, with both parties doing their best to make the union work. Constraints on late marriages include income and the sex ratio. The man must have an adequate income to support his partner, unless the woman can bring some financial resources of her own to the union. The sex ratio—nearly three women for every two men—places older women at a great disadvantage, particularly since most older men are already married. In addition, men tend to marry women who are younger than themselves, and thus die before their wives. Women are also poorer and are thus less attractive to a man who needs an adequate income to maintain a household. A final important barrier to late-life marriages is a strong social pressure against marriage in later life, attributable in part to our denial of older people's sexuality. Older people are very sensitive to this pressure and apparently need the encouragement of their families to overcome it.

Widows and Widowers

One partner in any marriage will eventually be widowed. Most often it is the woman, since men die younger and tend to marry women younger than themselves. Most women are widows by age 70, but a majority of men are not widowers until age 85.

The struggle of widows and widowers is suggested by their higher mortality and suicide rates, although these rates are highest of all for divorced people. Studies show that many older widows and widowers are preoccupied with grief, show a greater incidence of anxiety and depression, and fear death more than married people. As might be expected, morale is lowest for those who have been recently widowed. A spouse's long, taxing, and financially draining illness often leaves the widow with few emotional and financial resources to begin a new life.

Widowhood affects men and women differently; each sex must accomplish different adaptive tasks to make a successful adjustment after a spouse's death. Widowers are usually more secure financially than widows, and men have a better chance of finding a new marriage partner. Yet evidence suggests that men are more dependent on their wives for personal needs than wives are on their husbands. One study showed that more women than men have intimate friendships with others, a sex difference that appears to cut across age, educational, and social class levels. Also revealing is the finding that most men have their wives as their only confidantes, whereas most women have another woman as their closest friend. This suggests that men satisfy their needs for intimacy largely within marriage, while women satisfy such needs with friends as well as with spouse.

To sum up, the widower often has greater personal needs than a widow after the spouse's death. The man has frequently depended on his wife to "manage" his life in such areas as finances and self-maintenance. She is likely to have been his only close friend as well. If the widower can overcome these shocks, he has a good chance of adjusting and even finding another wife. If he remains emotionally isolated, he frequently develops some form of self-destructive behavior, a tendency which is reflected in the high suicide rates for older men.

In contrast, widows tend to be better prepared to develop close relationships with others, especially other women. However, they face greater economic need than men, and must also contend with general cultural discrimination against women.

The Unmarried

About one of every ten older people has never married; this group includes slightly more women than men. Somewhat surprisingly, the unmarried elderly appear to get along relatively well in old age, better perhaps than those who must adjust to the departure of children, widowhood, and the death of close friends. It seems that a lifetime of self-reliance prepares the unmarried for the autonomy and loneliness of old age. In their studies, Clark and Anderson found that many unmarried older people have never been close to many others and are thus spared the grief and loss of death. They also found that men and women remain single for different reasons. Unmarried men want personal freedom from involvement; they are often motivated by a desire to escape unhappy childhood experiences. On the other hand, some women never marry precisely because they wish to retain strong attachments to their families. Many older women have given up marriage in order to pursue a career. Whether the number of unmarried older people will rise or fall in the future is uncertain. For women, both marriage and career are becoming compatible aspirations. At the same time, social pressures to marry are weakening, and remaining permanently single is an increasingly acceptable lifestyle.

II
FAMILY AND FRIENDS

Most older people are part of a complex and often extensive semi-extended family system involving several generations. Many studies have documented the remarkable extent and variety of older people's kinship ties. Three out of four old people have at least one living child; one survey revealed that an astonishing 80 percent of this group had seen one of their children within the week preceding the survey. More than 60 percent of these individuals had seen one of their children within the previous two days. About 70 percent of all old people are grandparents, and 40 percent are great-grandparents. Four out of five old people have living brothers and sisters, and contact among them is typically quite frequent. Thus, the one million old people who have no surviving kin at all are the exception. Because they lack kinship support, these old people are in particular need of help from social service agencies, church groups, and other associations which can assume some of the functions of the family.

Family Patterns

While most old people have extensive and varied relationships with kin, the harder and more important question is to determine the quality of these relationships. There exists in the popular mind a feeling that these relationships are cool, and that they used to be much warmer a generation ago. However, little evidence exists to suggest that the three-generation family—with parents, grandparents, and children all living under one roof—was ever common. It appears to have existed as an unpalatable necessity forced on the poor, or as a temporary arrangement as a newly married couple moved in with one set of parents. Concludes Donald Kent: "The three-generation family pictured as a farm idyll is common, yet all evidence indicates that at no time in any society was a three-generation family ever the common mode, and even less evidence that it was idyllic."

Instead, about three out of every five older people are part of what Kerckhoff terms a "modified extended family." These groupings of grandparents, children, aunts, uncles, and other kin provide everyone with mutual support and affection. But family members do not live together. There may be conflicts between older people's values and the aspirations of their children, but there is no expectation that these conflicts will be resolved.

The rest of the elderly with kin are about equally divided between two other major family patterns. About one older person in every five is part of an extended family. Here, older people expect to live near their children and to receive considerable support and affection from them. They take a skeptical view of their children's mobility and aspirations, and expect to be involved in their children's major decisions. Extended families usually occur among people from rural, blue-collar, and ethnic backgrounds. Not surprisingly, relations between generations in extended families are often marked by conflict. The other 20 percent of the elderly expect what

Kerckhoff calls a "nuclear family" situation. Here, old people neither live near their children nor receive emotional support from them. People involved in nuclear families tend to be well-educated, city-bred, geographically mobile, and to have small families.

Kerckhoff observes that since the modified extended family has emerged as the American pattern, older people who expect the extended family are likely to be disappointed, while those who anticipate the detachment of the nuclear family are likely to be pleasantly surprised.

Parents and Children

By all accounts, most older people maintain very active relationships with their children; if anything, retirement seems to increase the frequency of such contacts. About 90 percent of older Americans with living children live less than an hour's trip from at least one of them. This percentage is even higher for widowed women. Contact is frequent. As noted, about 80 percent of older parents see one of their children at least weekly.

However, this contact occurs within a rather well-defined framework of mutual respect for the other party's independence. Clark and Anderson conclude that a good relationship between older parents and children in America depends largely on the older person's ability and willingness to manage gracefully by himself. At the same time, children are expected to establish their own lives. "In our culture," Clark and Anderson write, "there simply cannot be any happy role reversals between the generations, neither an increasing dependency of parent upon child nor a continuing reliance of child upon parent. The mores do not sanction it and children and parents resent it."

Obviously, an attitudinal shift on the part of both parent and child is necessary to accomplish a satisfactory adjustment to the rules of relationships in later life. The parent must relinquish his authority, and recognize his children's right to lead their own lives. Above all, parents must not make demands which interfere with the normal pursuits of their adult children. At the same time, children must outgrow their adolescent rebellion, and relate to their parents as mature adults. As Margaret Blenkner puts it, the child must turn again to the parent "no longer as a child, but as a mature adult with a new role and a different love, seeing him for the first time as an individual with his own rights, needs, limitations, and a life history that, to a large extent, made him the person he is long before his child existed."

Parent and child are more likely to make these adjustments successfully if both are mature, stable people established in secure emotional and financial positions. Emotional disorders, declining physical health, and economic need on either side make a happy parent-child relationship in later life more difficult to achieve.

Older men and older women must make different adjustments to the new parent-child situation. The older man must draw back from the potential contest of power and control that is inherent in the relationship between older American fathers and their grown American sons. He must step aside and "enjoy" watching the younger man succeed on his own. Since this posture is essentially one of detachment, the old man is less likely than the woman to become dependent on his children. On the other hand, the older woman is more sensitive to slights from her children and expects more from her relationship with them, possibly because she has invested more of herself in raising them than her husband has. Women tend to be more critical of younger people's child-rearing practices, manners, religious values, and drinking habits.

Because the differences between generations are so great, it is widely believed that most older parents and their adult children are alienated. Little evidence supports this supposition. Most parents and children seem to be able to work out their new relationships to their mutual satisfaction. Blenkner adds that most even manage to solve the crisis of eventual dependency. When the older person can no longer manage for himself, he expects his children to help. Children, in turn, usually render this help, particularly in terms of personal and protective services. There are many more impaired old people living in the community with the help of children and other kin than there are living in institutions. The myth of "abandonment" seems to be most widely held among social workers, who tend to work with older people who are in fact abandoned, and by childless older people who are really in no position to judge.

One sidelight of this topic is of particular interest: about one in every ten people aged 65 and over also has a child aged 65 or over. Mutual physical illness and financial need places an extra strain on many of these relationships, often requiring help from non-family sources.

Grandchildren

Although 70 percent of the elderly have living grandchildren, grandparenthood is a relatively inactive and unimportant social role for most people over 65. Most older people today adopt a "formal" style of grandparenting which leaves parental functions up to the parents. Also, most Americans first become grandparents during their 40s and 50s. By the time they reach retirement age, most of their grandchildren are likely to be complex adolescents. Some 40 percent of the older population have great-grandchildren. This role, unlike the grandparent role, does link those past 65 with young children. However, this can be unsatisfying too if the active, noisy great-grandchildren irritate and confuse the older person.

Grandmothers are more likely to develop a close relationship with their granddaughters than grandfathers with their grandsons. The grandfather's skills and experiences are usually obsolete to the younger man, while the grandmother often has pertinent lore about childcare, cooking, and handicrafts to pass along to her granddaughter. However, the changing role of the modern woman may tend to make grandmother's advice irrelevant to her as well.

Brothers and Sisters

The emotional distance between generations in American society seems to cause elderly brothers and sisters to place extra value on the relationships among themselves. As people grow into middle and old age, they frequently reactivate old ties with siblings that have withered during the years of younger adulthood. Older people visit their brothers and sisters frequently, often over great distances. Those with narrow social horizons are most likely to look to their siblings for emotional support. The intimacy of these relationships depends on the siblings' marital status. Widowed and single older people have more contact with their brothers and sisters than married older people. Strictures of privacy and independence also limit these relationships, just as they limit intimacy between parents and children. Needy and isolated older people are more likely to go to a single sibling for help than to a married brother or sister.

Summary of Kinship Roles

Clark and Anderson summarize the importance of kinship roles in these terms:

> A spouse is by far the major social asset an older person can have. Wives keep their men in touch with activities, and husbands provide their women with the emotional support they need. When one partner inevitably is widowed, he or she may be able to remarry. However, platonic relationships with special friends are the most common sources of spouse-substitution. This is so because there are many more widows than widowers, and women experience far greater difficulty in replacing a lost mate.
>
> Relations with children and grandchildren may be characterized by emotional distance. The generations are separated by the high value American society places on personal independence, by rapid cultural change which makes older people "obsolete," and by the conflicts generated as the offspring of first and second-generation American families become acculturated into the American pattern. However, relationships among brothers and sisters are frequently reactivated in old age and take on new life.

Friends

Friends are usually as important to older people as their kinship relations. In fact, apart from one's spouse, friends are the greatest source of companionship in old age. Since the friendship role is a flexible one—offering the degree of intimacy the older person desires—the individual's ability to make friends and to be a friend is usually a good indicator of his articulation with social reality.

Like most social relationships and associations among the elderly, friendships tend to be retained from middle age rather than begun and cultivated in old age. Older people do not ordinarily replace lost friends; they believe that this task is a difficult one, since potential friends are usually younger than themselves. Therefore, most older people's circle of friends diminishes as they grow older. However, a minority of old people report that they have *more* friends than ever before. These people tend to be widows who move into a circle of self-styled "merry widows" like themselves. Those older people whose friendships are most numerous and meaningful tend to be in good health, to have an adequate income, to be long-term residents of a community, and residents of a small town rather than a large city. Surprisingly, studies indicate that marital status has no effect on the older person's friendships. It appears that marriage does not supply all of one's needs for companionship.

Older people are selective in their friendships. They are likely to choose friends of the same age, sex, marital status, and socioeconomic group. The traits most prized in a friend are sensibleness, congeniality, and readiness to be of help if necessary. Older people seem to stress either the instrumental or expressive aspects of friendship. They view a friend in terms of what he could *do*—i.e., be of help in times of distress—or in terms of what he could *be*—i.e., someone who is pleasing and interesting to be with. The two traits are seldom viewed together.

Older men and women have different views of what constitutes friendship. Clark and Anderson observe that women seem to have an abundance of *friends* while men have many *associates*. Women talk more about their friends, place more value on such relationships, and more readily call on friends for help when they need to. On the other hand, older men are likely to have "friends" who are really distant associates: other men whose names they know, whom they see frequently, but with whom they have no close relationship. This is probably at least partially attributable to the masculine style of independence and self-reliance which most older men have adopted in the American culture. Many old men seem compelled to justify a lack of friends by claiming that they have deliberately chosen *not* to have friends.

As one would expect, friendship is a good index of the older person's emotional and mental health. Clark and Anderson report the rather startling finding that not a single man in their sample of older people with a history of psychiatric complaints could point to even one close relationship with a friend. On the other hand, skill at making new friends and sustaining friendships in adversity is an accurate indicator of the older person's success in adjusting to old age.

III
COMMUNITY ASSOCIATIONS

The social fabric of the American community is dominated by voluntary religious and secular organizations. In the small town, these groups often govern social, political, and economic life. In urban areas, they are important moorings in a sea of change and impersonality. They are doubly important for older people, because religious, fraternal, and union organizations do not explicitly exclude members on the basis of age. They remain a source of social contact, power and influence, and even social services for older people.

Religious Groups

Compared to younger people, the elderly attend church more frequently, hold more orthodox religious beliefs, are more interested in religious subjects, and are more likely to be members of churches and church-related groups. However, it is not clear that the level of religious involvement increases in intensity with age. It may be caused by a serious consideration of the meaning of life as death approaches, or it could be the result of growing up in a traditional society where religious observance and practice were considered more important than they are today. We don't know, because no one has yet studied changes in religious belief and behavior over the life span. Most of what we know about this subject comes from cross-sectional studies which compare older people and younger people at the same point in time. These studies have obvious and serious limitations, and conclusions are tentative.

Church attendance rises steadily from the late teens to the early sixties, when it begins to decline slightly and steadily. Those most likely to attend church regularly are Catholics, those with higher incomes, better education, and long-term residents of a community. Since some people go to church more often as they grow older, a larger number must stop going than the trends indicate. Many older people stop attending church because of illness and transportation problems, but maintain involvement through home Bible studies and watching religious broadcasts on television. Older people are more likely to read the Bible at home, to pray in private, and to describe Sunday as a day of religious observance rather than as a time to relax. Personal prayer and meditation are thought to increase with age, and even into late old age.

The available evidence indicates that religious activity is related to successful adjustment to aging, although it is not clear whether involvement fosters adjustment, or whether good adjustment fosters religious activity. Most religiously active older people say that religion is a more important part of their lives than it used to be, and older people are more likely to describe themselves as religious people. Contrary to popular belief, religious belief and activity do not protect older people from loneliness and fear of death.

Church organizations offer their older members a variety of services, ranging from high-quality institutional care to informal fellowship groups. Jews appear to offer the most extensive and effective programs. A number of Jewish housing facilities and welfare programs have international reputations for excellence. Catholics operate the most extensive network of residential and institutional care facilities, while Protestants emphasize special groups for older people in local churches.

Religious voluntary associations are second only to lodges and fraternal groups in popularity among older people. Membership in these associations increases until age 75, and leadership posts in these groups tend to be filled by older people. Older people also stay active in religious associations longer than in other groups.

Religious bodies appear to be strongest in providing institutional care and informal fellowship. They are weakest in the middle ground—practical, organized help for older people with various kinds of problems. The clergy usually confront the serious needs of older members of their congregations through contacts with shut-ins, hospital patients, and people in nursing homes. One study showed that while 80 percent of Presbyterian churches have special social groups for older people, only 13 percent have a special budget item to support a ministry for them. Very few offer help with employment, health services, or homemaking. Although studies have shown that older people are interested in studying religious subjects, it appears that only a small number of congregations offer special educational classes for them.

There is some indication that the situation is changing. The large Protestant denominations and the Catholic church have begun to create special national departments to promote social services for old people. Concern is being voiced over the fact that very few seminaries offer future clergy any training at all in working with old people. More than ever before, older members of religious congregations are asking their clergy to give them practical help, particularly with housing problems.

Voluntary Associations

Older people tend to be active in lodges, fraternal groups, clubs, and unions if they were active in such voluntary associations while they were younger. Membership declines with age, but women and affluent older people tend to retain their involvement longer. Men seem to have a slightly higher overall level of association membership, but this seems attributable to their membership in labor unions and service clubs. The small group of those who increase their association involvement seems to be made up principally of men who do so immediately after retirement and women who join groups after the last child leaves home. Many retired people join organizations of older persons.

Older people seem to value membership in associations because they want to remain in touch with other people in a structured group situation. The activities planned by these groups are not as important to older people as is the opportunity to interact with others in a congenial, familiar setting. A free, easy-going atmosphere is more appreciated than high-powered programs for self-improvement or social service. Clark and Anderson conclude that "What brings these older members to meetings is the implicit desire to remain within the flow of humanity, perhaps no longer playing as important a role there as before, but there nevertheless, to be of use again if called upon, still a functioning social unit, still interested, talking, alive."

IV

POLITICAL BEHAVIOR

Political participation is a diffuse notion, covering the mere holding of political opinions at one extreme and holding elective office at the other. In general, older people are disposed toward a high degree of political participation. As most candidates for elective office know, older people vote and tend to be well-informed about issues. They also exert a disproportionate amount of influence in political organizations. Elective and appointive office represent one position of power and influence from which people are not automatically excluded on the basis of age. It is possible for an older person to sustain a political career almost indefinitely.

Although older people are more likely to have "no opinion" about questions on political polls, analysis shows that those above age 65 are more likely to have political opinions if the effect of their lower levels of education is controlled. The tendency to have opinions increases with age among those who have strong roots in the community. This high degree of opinionation seems to be related to older people's desire to be informed about politics and government. Compared to younger people, the elderly follow political campaigns more closely, are better informed about issues, write to their Congressmen more frequently, and even seek out academic knowledge about governmental matters. Norval Glenn, a sociologist who has studied the subject, found that the citizens who are most interested in politics tend to be over 60 years old.

Older people translate this interest into votes. Voting frequency is lowest at age 21, builds to a plateau of about 80 percent at 65, and then declines gradually. However, individuals in their 80s still vote more often than those in their 20s. Those with more education vote more frequently. Glenn discovered that voting patterns remain extremely stable throughout adult life. He suggests that people settle on a style of voting behavior in their 30s and 40s and then stick to it. This finding indicates that as better-educated generations grow old, older people in the future may vote even more frequently.

The strength of party affiliation seems to depend on its duration. A person in his 20s is only half as likely to be a party member as a person over 65. The proportion of people who identify with a party increases gradually with age but does not decline in later years as voting behavior does. Older party members are about equally divided between Republicans and Democrats. Some data suggests that the older population will begin to reflect a preponderance of Democrats as those who grew up in New Deal days grow old. Other studies have found a slight drift of older Democrats to the Republican Party with age. On the other hand, Americans in general are becoming less disposed to identify themselves as members of a political party, and more likely to call themselves Independents. Those who are party members are less likely to vote a straight ticket.

While research in this area is tentative and somewhat contradictory, there is little evidence to support the popular belief that people become more conservative as they grow older. Older people are conservative in comparison with today's younger people, but not necessarily in comparison to their younger selves.

Older people are more highly represented in political organizations and in offices than other age groups. This is so because sheer tenure and length of service carries more weight in politics than in other social organizations. Political prowess is still something learned more from experience than from a book or in school.

Rather surprisingly, Glenn found that older people become more cynical about politics even as they become more active and interested in the political process. They seem to vote regularly and become more politically knowledgeable while simultaneously doubting that individual action can have much effect on the political process. Glenn feels that older people turn to politics because they have no other absorbing interests and activities. As one grows older, the older person views politics more as a means of personal fulfillment than as a means to an end.

Political Power

The notion that older people constitute a potentially powerful interest group has long intrigued political scientists, reformers, and some gerontologists. Some have argued that the politically astute older voting population should be able to unite around a program and force concessions from political leaders. Two examples of such political power stand out on the national level: militant, impoverished old people organized in the Townsend Movement hastened the passage of the Social Security Act in 1935. Thirty years later, sophisticated lobbying by Senior Citizens for Medicare —now the National Council of Senior Citizens—helped push Medicare through the Congress. Today, a national organization of older people called the Gray Panthers is emerging and will bear watching.

However, age does not appear to be a sufficiently powerful unifying force to be the basis for a political coalition of older people. First, older people interact across generational lines more frequently than they do within them. The sense of group identity among racial minorities, union voters, and other interest groups does not exist among older people. This violates the first requirement of interest group politics: the ability to deliver a block vote to a favored candidate. In fact, there is no instance in American history of older people voting from an interest group consciousness. Also, party ties tend to be strong among the elderly; they are less likely to desert the party and vote for its opponent on a specific issue. Although older people vote and tend to be well-informed, politicians are often tempted to take their votes for granted and pay lip service to their demands. Finally, older people are too dispersed geographically and socially to be a large, concentrated voting block.

However, older people *do* exert a measure of political power. Politicians and parties have their programs for the elderly; legislation is enacted regularly in the Congress and in state legislatures. Hardly any group dares to oppose such measures as higher Social Security benefits, better Medicare, and reduced fares for older people on public transportation.

The nature of this power seems to lie in older people's capacity to influence other groups of voters and gain their support for particular programs. Old age political organizations, such as the National Council of Senior Citizens and the American Association of Retired Persons—National Retired Teachers Association, have been effective in influencing labor unions, Congressmen, political parties, and political candidates. The particular "cause" succeeds if older people and their organizations can convince other, more powerful groups to pick it up and include it in their own programs.

This indirect style of political action promises to yield the greatest benefits for older people in the future. Most political scientists agree that older people are best served in the political process if their needs are incorporated into the program of a large, powerful coalition which cuts across age lines. The alternative strategy—to compete head-on with other interest groups—has not been notably successful in the past. The coalition approach also seems more realistic in terms of the nature of older people's needs. Such needs as better transportation and a more responsive health care system can be met only through major political change supported by a broadly-based coalition.

V

SOME ISSUES IN SERVICE DELIVERY

Extensive as it may seem, the network of social relationships that surrounds older people cannot meet all their needs. A significant minority of the elderly have minimal contact with kin, friends, and community and religious organizations. For others, their social network is incapable of supplying many vital services. Thus, many old people must increasingly turn to their community's formal system of social services. This chapter concludes with a brief discussion of some of the issues involved in delivering these services more effectively.

Availability

The overriding issue which probably every serious student of the problem ranks first is the limited extent to which services are available to older Americans. There are simply not enough homemakers, visiting nurses, social workers, counselors, and health aides available to meet the need. For example, nursing encompasses a whole array of service which could keep older people functioning at home despite frailty and disability. But if older people whose conditions do not require 24-hour care are to be able to remain at home, a substantial network of supplementary home help, home maintenance, and personal care will be required. These services do not currently exist on any notable scale. On the contrary, most nursing service available to older Americans is supplied in nursing homes.

The many reasons for the general unavailability of social services for the elderly are historical, psychological, and speculative. The social service system in the United States is heavily oriented toward young people. Aid to Families With Dependent Children is the largest welfare program. Other services are directed toward delinquents, addicts, and unemployed and unskilled youth. This emphasis on the young seems to reflect a national priority. Young people represent the future of a future-oriented society, while old people represent the past. Deprived, unemployed, alienated youth pose an immediate threat to the fabric of society. Old people, needy as they may be, seldom pose any threat to the social order.

The vast expansion of social service and anti-poverty programs during the 1960s subtly intensified this bias in favor of youth. The infusion of money and energy into human service programs was accompanied by a new theory of service which stressed the quality of life and equality of opportunity instead of the traditional service goals of survival and crisis intervention. This theory was most readily and vigorously applied to young people—those with a future. It tended to ignore old people, who still need social services to survive. Most receive human services when they run out of personal and familial resources. Agencies will then provide a minimum of income, food stamps, a bed in a nursing home or hospital, perhaps a surrogate to take over financial affairs.

It is interesting to note that the service system's priorities are reversed in most Western European countries. There, the major human service concern is care for the nation's population of old people. In particular, welfare states such as Great Britain and Sweden have constructed elaborate networks of supportive home services intended to enable old people to function in the community and to remain out of nursing homes and other institutions.

In contrast, the American system of social services reflects a conscious decision by political leaders and policy-makers to deal with the elderly through Social Security, welfare assistance, and other income maintenance programs. They decided to deal with the young through social "services"—counseling, recreation, jobs, job training, education—the services which are conspicuously unavailable to the old. Whether services will become more available to older Americans depends largely on whether older people will become more insistent, more visible, more politically astute. Public and private agencies will expand services for the elderly if they are required to by political pressure. As noted earlier, the nature of older people's political power seems to lie in their ability to influence other voters and gain their support.

Fragmentation

If the overriding human service problem is limited availability, the second difficulty is the existing system's fragmentation and discontinuity. Many students of human services argue that there is no system. In most communities, the services that old people need are provided by a complex of public, non-profit, and private agencies. All are essentially autonomous. Each is structured to provide one type of service in its own setting and through its own procedures. Few are particularly responsive to older people and rarely does a provider of human service make an attempt to assess an older person's needs on a comprehensive basis. Consequently, the older person performs his own diagnosis. He must assess his own usually multiple needs and seek out the combination of agencies that can meet them.

Fragmented service has two important consequences. The first is that no single agency is likely to be able to meet all of an older person's needs. He must therefore cope with several bureaucracies rather than one. The second consequence is more subtle and perhaps more important. Neither the client nor the agency may be aware of the true nature of the old person's problems. Both may have a grossly over-simplified view.

For example, the late Donald P. Kent, one of the most perceptive students of this subject, was once puzzled to find that very few low-income elderly in Philadelphia thought that transportation was a problem for them. Exploring the matter further, he found that most old people in neighborhoods with deficient or non-existent public transportation complained about loneliness, lack of contact with children, and isolation from medical care. Neither the old people nor, at first, Kent himself, realized that these problems were largely caused by the lack of transportation.

Kent gave another example of how fragmentation confounds the practitioner. An old widow was advised by an ophthalmologist to have an operation for cataracts. She refused to undergo the operation for two reasons: no one had explained to her what cataracts were, and she would not leave her home empty to go into the hospital. To see her problem as only a medical one was to miss the interrelatedness of life. By simply concentrating on the widow's medical problem, the doctor failed.

Some more specific issues relating to the fragmentation of services include the following:

Information. A major block to the delivery of services is simple information. Old people in need do not know services are available and providers of services are not in contact with the elderly. Kent found that 10 percent of his sample of urban elderly had serious problems requiring immediate attention. Yet the old people had no idea of where to find help, and none of them had been approached by any outreach worker. For example, Kent found many old people needing dental care. In Philadelphia, where Kent conducted his surveys, anyone could obtain such care by a simple phone call to the City Health Department, which had mobile dental equipment. Yet old people did not know such a service existed, and dental specialists sat in their offices awaiting calls.

Agencies which try to publicize their services usually do so through the printed word. This is probably the least effective way to communicate with old people, particularly poor elderly. Literacy is often at a low level. Agencies tend to use a legalistic vocabulary which protects the agency, but which is less than comprehensible to the elderly. Radio is also relatively ineffective. Old people often have radios playing all the time, but they mostly provide background noise, not information. On the other hand, television is a very effective communication tool, while the most effective means is personal contact between individuals who trust each other.

Accessibility. Administrative coordination of human services tends toward physical centralization. The task of coordination is much more difficult when services are provided in many locations. Yet a higher degree of decentralization seems to be essential for older people. The "life space" for most old people—particularly the urban elderly—is frequently quite limited. At times, their lives are lived in an area encompassing a few blocks, with a grocery store on one end and a drugstore on the other. To ask them to travel many miles to a central office downtown to obtain services poses a severe psychological as well as a physical obstacle. Again, the deficiencies of public transportation are a great barrier to service delivery, one which is often overlooked. Finally, centralization of service in distant locations reinforces many old people's impression that government is remote, unresponsive, and a place of last resort.

Bureaucracy. A related problem is the bureaucratization of human services. Most of us have grown up with bureaucracies—indeed, we work in them. We know how to fill out forms, walk from office to office, and tell the same story to a succession of people. Yet standard bureaucratic procedures are often bewildering and frightening to older people. Many older people are deprived of service because they are thwarted by a bureaucracy they can neither comprehend nor cope with.

This problem is magnified by the fragmentation of services. An older person with multiple needs must seek relief from multiple agencies. The more people he has to deal with, the greater the chances that interpersonal problems or bureaucratic mysteries will thwart him.

Interpersonal Issues

Much of the generalized criticism of the way human service professionals treat their clients can be applied with special force to services for the elderly. The general complaint is that professionals treat their clients more as items to be processed than as people to be served. This is frequently the case when older people seek service, and the stigma of being old in America magnifies the problem. Too many human service professionals see older people in need as merely helpless individuals. The services they provide too often stress treatment at the expense of care and maintenance at the expense of rehabilitation.

Older people's attitudes also complicate the provision of humane social services. The professional or outreach worker must often be very adroit to overcome the old person's fear that an agency's intervention in his life will lead to the loss of his freedom. The desire to remain independent is a primary motive among older people. Ironically, many older people exhibit a certain passivity and submission to authority when they deal with the bureaucratic agency. The burden of responsibility for overcoming these obstacles lies with human service staff.

CHAPTER 8

ETHNIC AND OTHER MINORITIES

This chapter draws special attention to minority groups of older Americans. In the case of ethnic minorities, the need for special concern is quite familiar and well-documented. Blacks, Latinos, Indians, and other ethnic groups have unique cultural characteristics which require knowledge and sensitivity on the part of others who interact with them. These same cultural patterns have placed minority people in a lower status within the dominant white culture. This status, in turn, magnifies the extent of their need.

In this chapter, we also very briefly discuss urban and rural elderly, widows, and elderly with vision and hearing problems. Here, the need for special attention is perhaps less clear; taken together, these "minorities" constitute a majority of older people. Nevertheless, they have minority status precisely because their particular characteristics are seldom noted. And, like ethnic minorities, these characteristics bring special needs and thus require special consideration.

I
ETHNIC MINORITIES

Elderly members of minority groups vary tremendously in their social situations and cultural characteristics. One compares an elderly black living in New York, an Indian on a reservation in Michigan's Upper Peninsula, and an older Mexican-American in a Texas town with great caution and many disclaimers. Yet these minority groups of older people share a common vulnerability in their old age. Their condition is one of triple jeopardy: they are vulnerable because they are old, because they are poor, and because they bear the often considerable burden of minority group status within the dominant white Anglo culture.

Older blacks, Indians, Latinos, and other minorities share other characteristics. For one thing, they are not as numerous as one would expect. About 10 percent of all Americans are aged 65 and over. But this percentage falls off sharply for minority groups: 7.0 percent for blacks, 6.8 percent for Cubans, 5.7 percent for Indians, 3.2 percent for Mexican-Americans, and 2.0 percent for Puerto Ricans. Educational levels show a similar pattern of deprivation. For example, the number of older Mexican-Americans who have completed less than five years of school is six times higher than the ratio for the total over-65 population. Less than one percent have completed high school.

The major common experience of older minority people is poverty. Social Security increases, which lifted 1.5 million white elderly from poverty between 1967 and 1972, have had a much more modest impact on ethnic minorities. This is so because a much higher proportion of minority older people have never acquired a record of covered employment sufficient to entitle them to Social Security. Not only have they suffered high rates of unemployment; many of the menial occupations open to minority workers—migrant labor, domestic work, and day labor—have been included under Social Security only in relatively recent years. A second reason why Social Security benefit increases affect minority elderly more modestly than whites is because across-the-board benefit boosts are applied to a much lower base. A 10 percent hike is worth more to a white couple drawing $300 a month than it is to a black woman receiving $100. As a result, Social Security benefits are 26 percent higher for white retirees than for blacks.

We can do little more here than summarize some of the major socioeconomic characteristics of minority elderly. A discussion of the particular cultural and ethnic aspects of each minority is beyond the scope of this book. To some degree, it is beyond the scope of gerontology as well. While sociologists and other academic investigators know much about minority cultures, they know very little about the special characteristics of minority elderly. This vulnerable and poorly-understood population is only now drawing the attention of serious, trained investigators. Recent steps such as the creation of the National Center on Black Aged are exceedingly welcome.

Black Elderly

The problems faced by the general older population are magnified for the black elderly. As a group, the 1.6 million black Americans aged 65 or over are poorer, sicker, less educated, and possess a greater need for better housing and transportation than white older people. One shocking and unexplained statistic suggests the scope of this deprivation. Between 1960 and 1968, the life expectancy of black males at birth *declined* a full year—from 61.1 to 60.1 years. They now can expect to live seven years less than white men, and black women nearly eight years less than white women. Since the life expectancy of black men is below age 65, many will never reap the benefits of Social Security and Medicare—programs to which they may have been entitled.

However, one intriguing statistic suggests that blacks and other minorities possess a strength whites may well envy. For very advanced age groups, the trend in life expectancy is reversed. For example, an 85-year-old black man can expect to live an additional 9.5 years, while a white 85-year-old can expect only 4.9 years of life. Of the 7,000 centenarians receiving Social Security benefits, 12.5 percent are blacks, even though blacks constitute only 7.0 percent of the over-65 population. Some authorities speculate that minority elderly who are able to survive earlier hardships are especially hardy and durable.

Nearly two-thirds of all elderly blacks live in the South, the area of the country where social services are least well developed. As with black citizens in general, the rest of the black elderly population is about evenly divided between the Northeast and North Central regions, with only five percent of black elderly living in the West. While the movement of younger blacks to the cities has left a disproportionate number of their older relatives in rural areas, the steady movement of young black families to the suburbs has left the older people over-represented in cities as well. For example, the number of elderly blacks in Detroit nearly doubled during the 1960s.

Older black people are fighting a losing struggle against poverty. During 1972, while 500,000 white elderly left the poverty rolls, poverty among older blacks increased by 17,000. The percentage of black elderly living in poverty grew from 39.3 percent in 1971 to 39.9 percent in 1972. This happened while the poverty levels among the total over-65 population dropped from 19.9 percent to 16.8 percent.

Black old age poverty is concentrated among women and those living alone. A stunning 68 percent of black women living alone subsist on less than $2,000 annually. The figure for males is only slightly lower—54.7 percent. One-quarter of all elderly black families headed by a man survive on less than $40 a week. The comparable percentage for white households is 9.5 percent. The magnitude of this poverty both overshadows and leads to other deprivation. As with other poor old people, the poverty of black elderly brings substandard housing, chronic illness, malnutrition, and immobility.

Jacquelyne Jackson, one of the leading advocates for the black elderly, urges social service systems to become more responsive to their needs. However, she cautions well-meaning planners and social workers not to interfere with the effective extended family system which surrounds many older blacks. It is common for elderly blacks to be important supportive resources for their children and grandchildren, helping with food, housing, income, babysitting, and other essential functions. "They may suffer significant familial role losses if society does not intervene in black lives carefully," she says. Rather than undermine these strengths, those who serve black elderly should build on them.

Spanish-speaking Elderly

About 322,000 Americans aged 65 and over are Spanish-speaking, although most experts think that spotty Census coverage makes this figure misleadingly low. About half the Latino elderly are of Mexican origin. They are concentrated in three Southwestern states—Texas, New Mexico, and Arizona—with other large populations in California and Colorado. However, large and usually hidden groups of Mexican-Americans live in most of the Midwestern industrial states. Many came originally as migrant farm workers and settled down to take better jobs in industrial plants.

About 30,000 elderly Puerto Ricans and 40,000 elderly Cubans live in the United States. Concentrations of both groups are found in New York City and northern New Jersey, while the largest group of elderly Cubans lives in Miami and South Florida.

Spanish-speaking elderly—particularly Mexican-Americans—are not ordinarily connected to Social Security or to any part of the social service system. The language barrier is a particularly serious problem for these elderly, most of whom speak English poorly if at all. To serve the Spanish-speaking old people effectively, social agencies must expect to provide bilingual personnel. In most instances, federal offices and other Anglo-dominated agencies have successfully improved their services to Latino people when they supply bilingual personnel. What seems to be needed is a stronger commitment to broaden and sustain such effort. Like blacks, Spanish-speaking elderly are usually engrafted into a protective extended family and seek social services only as a last resort. Finally, many are reluctant to approach public agencies because they are concerned about their citizenship status and are fearful of being deported.

Elderly Indians

The problems of the American Indian are in many ways the most serious facing any minority group. Indian tribes and families have great difficulty meeting their fundamental needs. Most Indians, and the vast majority of old Indians, live as wards of the federal government on reservations, some of the poorest land in the country. There are reservations in 24 states, including such populous industrial states as New York, Florida, Michigan, and California. The government's Indian policies have been erratic. They displease most Indians and have strong critics within the government itself.

The Indian elderly, in particular, could very well be the most deprived identifiable group of Americans. For most, English is a second language, if they speak it at all. They live on little or no income, in housing which is the worst for any population group in the country. Most have had no formal education. Since unemployment rates on Indian reservations average 50 percent, few have ever worked steadily. Only one of every three Indians and Alaskan natives will reach age 65—exactly half the rate for the American population as a whole.

Asian American Elderly

The majority of Asian Americans live in the West, with the two largest concentrations in the San Francisco Bay area and in Honolulu. However, most larger American cities also have Asian communities, particularly groups of Chinese Americans. Data about elderly Asian Americans is sparse, but most surveys indicate that the traditionally close kinship ties in Asian American families are beginning to erode in the urban centers, leaving many elderly in need of social services. Language barriers and the traditional reluctance to rely on outside help are obstacles to the use of services for Asians, as for other minority groups.

II
OTHER MINORITIES

Urban Elderly

About a third of America's older people live in the central cities and bear the brunt of our worsening urban problems. Housing is scarce, expensive, and inadequate. Public transportation deteriorates. Streets are crowded and dangerous. Street crime is brutal and terrifying. The cost of living is higher than in non-urban areas. The pace of urban change is breathtaking and inexorable, transforming old neighborhoods again and again. Many urban elderly are in a condition that has been termed "multiple jeopardy." They grow old in a social environment which complicates the adjustments they must make. Margaret Clark describes the urban elderly in these terms:

> We do know from comparative studies that the inner city elderly are, both physically and psychologically, sicker than their age peers in other groups. They have a harder time surviving—perhaps the hardest of any elderly cohort we know. No one lovingly watches over the destinies of these tough survivors. They survive by their wits, like the rats that are often their only company. Whether they are "loners" or elderly couples, they usually are stubbornly trying to maintain the American ethic of individualism and autonomy as primary values in their old age. These were the standards by which they were raised at the turn of the century, and although they know that times have changed, they still cling to the old ideals. For this fidelity, they pay a high price. Unlike some in the ethno-minority groups (e.g., older Negro women, Oriental grandparents, etc.), the White, impoverished inner-city aged lack the familial supports and the respect of others which sustain the waning powers of those in certain minority groups. Although they are not as isolated from their kind as was once supposed, their life-style seems to exemplify isolation, social invisibility, and—above all—grinding poverty.

Nevertheless, many older people clearly prefer a perilous life in the city to a problematic move to the suburbs or a rural setting. Like any other environment, the city has the potential for fostering either human misery or human well-being. Attempts to improve conditions of urban elderly should exploit the advantages of the city, including its variety, activity, economic resources, relative mobility, and reasonably well-developed network of services.

Rural Elderly

A quieter crisis in rural America also victimizes the nine million older people who live outside metropolitan areas. The problems confronting rural communities include depressed economic conditions, a critical shortage of health personnel and facilities, limited job opportunities, dilapidated housing, inadequate or nonexistent public transportation, and an eroding tax base. (Sometimes the opposite kind of tax problem obtains in rural areas. The outward push from the suburbs leads to irresponsible land speculation, and property values explode. Result: farmers are forced off their land because they cannot pay the property taxes.) In many rural areas, especially in the Midwest, the exodus of young people to the cities has left behind a population composed of as much as 20 percent old people. The rural elderly are poor (a third of the men and more of women have annual incomes below $2,000), live in substandard housing (15 percent of the substandard housing in America is occupied by rural elderly), isolated, and more likely to be chronically ill and disabled.

In its special section on the rural elderly, the 1971 White House Conference on Aging concluded that rural transportation problems must be solved before there can be effective solutions to rural health, income, employment, or housing problems. The conference also recommended special programs for home repair, protective services, health care delivery, tax relief, and employment for rural elderly.

Elderly Widows

Gerontologists have begun to suggest that the 6.1 million older widows in America constitute a minority group in their own right. Widows are the largest group of older people who live below the poverty line. Nearly four million live alone, many isolated from family, friends, and community. In addition, they are victimized by special prejudices. As women, they are at a disadvantage in a male-dominated society, especially in the area of employment. They also suffer from the prejudice against single and divorced people. Finally, many friends avoid women after they are widowed because of a distaste for the reality of death. In view of these personal and socioeconomic needs, a major effort to improve the condition of widows should be undertaken.

Elderly with Vision and Hearing Problems

Ten percent of all older people suffer from visual impairment, and nearly half have hearing problems. Of the two, loss of vision limits activity more seriously. About five percent of the elderly are so impaired that they cannot read newsprint, or recognize the faces of friends or see moving objects. Vision loss is most frequent among non-farm rural older people. It is also more frequent among non-whites, the poor, and those over 75. Prompt medical attention and regular examinations can relieve many of these problems, especially cataracts and glaucoma—the commonest causes of visual impairment.

Hearing impairments are common among older people, but they are serious enough to limit activities in only about one percent of the cases. However, even moderate hearing deficiency can contribute significantly to the older person's sense of caution and suspicion as he tries to negotiate an environment he perceives imperfectly. Many cases can be greatly helped by hearing aids. However, the hearing aids should be fitted by someone trained to treat hearing deficiences, and not by someone primarily interested in selling hearing aids.

CHAPTER 9

MALADJUSTMENT: MENTAL DISTURBANCES IN LATER LIFE

I
PSYCHIATRIC DISORDERS

Individuals are judged "mentally ill" when various social institutions decide that their behavior violates certain norms. Not all "abnormal behavior"is termed "mental illness." In fact, some psychiatrists argue that "mental illness" cannot be defined medically, but exists only as a social and legal category. This does not mean emotional disturbance is a myth, or that maladjusted people do not suffer and cause others to suffer. It does mean that we must use psychiatric terminology carefully. Almost everyone has at some time experienced severe anxiety, depression, sleeplessness, and restless concern with the state of one's body. These and other disorders become "neurotic" or "psychotic" when they lead to serious behavioral disorders, and come to the attention of relatives, friends, landlords, private physicians, police, judges, and hospital personnel.

This understanding of "mental illness" serves to underline the fact that maladjustment among the elderly is a product of their total situation—cultural and environmental as well as physical and psychological. To include this chapter does not suggest that maladjustment is a universal experience of the elderly. While most older people may experience an occasional symptom of emotional distress, these symptoms do not need to be elevated to the status of "disorder" in all or even most cases. However, the problem of maladjustment and emotional disorder is common enough among older people to make a discussion of it useful.

Anxiety

Anxiety, a complicated psychophysiological response which nature has provided for emergency situations, often becomes chronic in old age. The old person may experience anxiety as a vague but persistent dread. It can be accompanied by muscular tension, restlessness, rapid heart rate, and excessive sweating. If the anxiety cannot be relieved, any of a number of psychological defense mechanisms may swing into action to protect the individual from this hyperactive state. These include rigid thinking to close out anxiety-producing stimuli (the person "hears" what he wants to hear), extreme suspicion, sleep disturbances, depression, and hypochondria.

Anxiety is often rooted in a generalized fear of growing old. Many older people, particularly those with a ruggedly individualistic orientation, cannot face the dependency which old age often brings. Thus they become extremely anxious. Anxiety is also a common response to situations where the individual must learn something new and cope with substantial change. Old age is one of life's most complex and difficult periods, requiring the individual to assimilate vast quantities of new information about his body, mind, and environment and to adjust accordingly. Anxiety can be a useful response to prepare the individual to meet a special challenge. However, it can severely cripple the older person's capacity to adjust if it becomes persistent or extreme.

Sleep Disturbances

Sleep disturbances of all kinds are among the most common complaints of old people. Some have trouble going to sleep, some wake up frequently, some awake tired in the morning, some suffer from chronic insomnia. Various studies indicate that between 20 and 40 percent of all old people use sleeping pills habitually.

Sleep disturbances are frequently related to anxiety and emotional conflict and are often the signs of a deeper disturbance. However, sleep problems in old age also have a physiological basis. Old people seem to require somewhat less sleep than young people. They also take longer to fall asleep, sleep more lightly, and wake up more often during the night. The stage of deep sleep virtually disappears. Old people can be relieved of much anxiety over their sleep problems if they understand that such changes in sleep patterns are normal.

Depression

Recurrent periods of depression, of varying intensity and length, are perhaps the most common neuroses of old age. Various studies indicate that as many as two out of every five older people complain of more frequent and troublesome depressive episodes in later life than they ever experienced before. Old people suffering from the milder forms of depression feel discouraged, worried, useless, and bored. Physical complaints include sleeplessness, sexual impotence, fatigue, loss of appetite, and constipation. One interviewer reported that many "normal" older people with no overt psychiatric problems told him that they suffered depressive episodes severe enough to include longing for a painless death.

Psychotic depression can be even more severe, and it accounts for about half the admissions of people over 60 to private psychiatric hospitals. Here the depressed person's feelings of disgust and uselessness often lead to suicidal thoughts and actual suicidal attempts. The person is darkly pessimistic and suffers frequent crying spells. Sometimes the depression is so severe that the old person's thought processes are impaired; he cannot answer questions, solve simple arithmetical problems, or identify the time and place.

Psychiatrists are unsure about the major causes for depression in old age. Some say that a feeling of overwhelming loss—linked to actual losses suffered in advanced age—brings on the depression, particularly the milder varieties. Their treatment approach emphasizes restoring the patient's feelings of self-worth through useful and productive activities and regular contacts with other people. Psychiatrists of this opinion say that hobbies and other leisure activities are of little use to the depressed older person unless they lead to the production of something useful.

Other psychiatrists believe that the classical theory of depression—hostile impulses turned inward—holds true for old age. In this view, depression is a destructive response to the loss of a person or object held ambivalently. The depressed older person turns toward himself the vindictiveness, anger, bitterness he felt toward the lost person or object. Indeed, many cases of depression in old age develop from grief and mourning following the death of a spouse. These theorists suggest the survivor turns hostility toward the dead partner in on himself in the form of guilt and self-recrimination.

Treatment of severe depression among old people is frequently difficult. The risk of suicide is very great, and effective treatment often requires hospitalization. Psychotherapy is usually relatively ineffective by itself because severely depressed people are often unable to carry on a dialogue with the therapists. However, drug therapy and electroshock treatment are usually highly effective in ending depressive episodes.

Hypochondria

Hypochondria, an anxious preoccupation with the state of one's body, is often associated with depression in old age. However, it is a neurotic disturbance in its own right and appears frequently among old people, particularly women. Even though most of us may occasionally "play sick" to avoid unpleasantness, we find hypochondria annoying. The attitude of the chronic complainer's family moves from concern to suspicion to exasperation. The busy physician refuses to take the hypochondriac seriously, and gets him out of the office as rapidly as possible. Such attitudes feed the emotional disturbance that led the hypochondriac to take refuge in imagined illness in the first place.

Many older people who keenly suffer the loss of their independence and status are subconsciously attracted to the "sick" role because it absolves them of personal responsibility for supposed failure. The sick person is assumed to bear no responsibility for his condition and thus has a right to be taken care of. For the old person, this means he can have the concern and attention from others that he would not receive if healthy and well. Emotionally, illness can be a convenient way to repress or deflect hostile feelings toward others. Cataloguing pains and symptoms allows the hostile old person to punish himself for his feelings and to atone for guilt.

One study revealed that one-third of a group of old people living independently had high levels of bodily concern, and that the concern was neurotically based in half these cases. Most of these hypochondriacs did not seek medical care, but used their illness as a social crutch to ward off their anxiety and to elicit sympathy and attention. Many psychiatrists think that hypochondria is a relatively treatable condition. It means that the old person is asking for help, not withdrawing, and his family and physician can aid him by pointing out patterns in his behavior and guiding him toward more constructive ways of resolving his inner conflicts.

Paranoid Reactions

Paranoid symptoms, usually involving a delusion of persecution, occur in people of all ages but are most frequent among old people. These reactions range from elaborate, well-organized paranoid systems, where the individual considers himself endowed with superior powers, to mild, transient episodes. Paranoid suspicions are not entirely outside the range of normal experience. Many of us have at one time or another detected plots against ourselves among neighbors, friends, or associates. Too often, some suspicion is justified.

Old people are especially vulnerable to paranoid reactions because the situations that foster suspicion at any age are more frequent in old age. These include social isolation, anxiety, general insecurity, and sensory deficits, particularly hearing loss. Decline in sharpness of vision and hearing with age renders large segments of the external surroundings vague. The old person must fill in the blank spaces, and he often finds hostile and threatening forces lurking there. While younger paranoids blame esoteric, remote forces for their misfortune, the old person usually latches on to nearby figures—neighbors, the mailman, others in the house, his children. Children in the neighborhood are thought to be spying, the man upstairs deliberately pounds the ceiling at night, neighbors are laughing at him, and his family is plotting to send him to a nursing home.

Paranoid symptoms, while frequent in old age, do not have the same ominous significance as they have for younger people. Many are rather whimsical. One psychiatrist cites the case of an otherwise well-adjusted 80-year-old widow who was convinced that neighbors were dumping lint into her washing machine. She got along well with everyone, except on washing days. Of course, paranoid reactions can be quite serious, leading to serious personality disturbances, institutionalization, and even murderous rage. Drug therapy has proven to be a very effective treatment for psychotic paranoids.

Suicide

In the last 50 years, suicide has increasingly become a disorder of elderly people. People aged 65 and over constitute about 10 percent of the U.S. population, but they account for about a quarter of the suicides. Men are much more likely to commit suicide than women. The suicide rate among aged white men is about six times greater than for the population as a whole. When an old person sets out to kill himself, he nearly always succeeds. Younger people often fail in their suicide attempts because they are essentially expressing hostility toward someone or trying to bring someone to terms. When an old person tries suicide, he usually intends to die.

More than half the old people committing suicide have been depressed. Feelings of self-hatred and hatred of others usually underlie these depressions. A smaller number of suicides are alcoholics and heavy drinkers, but frequently the drinking has been self-administered medication for depression. The third largest group of suicides is composed of those who suffer from organic brain disease. A surprisingly small number of older people commit suicide because they have a terminal illness.

Psychiatrists find no satisfactory explanation of why suicide should be so much more common among men than women. Depression, the leading "cause" of suicide, occurs at least as frequently among women as men. It is also unclear why the frequency of suicides among men increases lineally with advancing age, while female suicides peak in the late forties and then taper off. Also, suicide rates among blacks and other minorities are much lower than those for whites. Perhaps minority aged are better able to live with poverty, dependence, and degradation because of their lifelong familiarity with these conditions, while old white men find the hardships of old age intolerable.

Suicide in old age seems associated both with loneliness and with a poor living situation. The highest suicide rates are among divorced men, followed by widowers and those who never married. Those committing suicide are also likely to live alone, usually in a deteriorating section of a central city.

Suicide is only one way old people express their despair. Instead of committing an overt suicidal act, many choose slower, indirect means of self-destruction such as refusing medication, drinking too much, refusing to eat, avoiding physicians, and allowing their homes to deteriorate into squalor. There seems to be a close link between a mental attitude of hopelessness and the onset of serious disease. One medical team found that three-quarters of a group of seriously ill old people felt like "giving up" just before their illness developed. The doctors speculated that the physical-emotional constitution of older people was so fragile that hopelessness triggered a precipitous physical decline.

Crime

Criminal activities decline with age; violent crimes disappear almost entirely. Arrest rates of old people are only one-quarter of the rates for the general population. Old people are arrested most frequently for public drunkenness and disorderly conduct. These offenses accounted for 80 percent of the arrests of people aged 60 and over in one study of San Francisco's crime statistics. Another 10 percent were arrested for petty theft and for traffic offenses. Only two percent of the arrests were for offenses against persons, and only one percent involved sexual offenses.

The evidence indicates that sexual deviations among older people—the "dirty old man" stereotype—are much more rare than commonly believed. Sexual pathology is related to young adulthood; violent sex crimes in old age are extremely uncommon. Most of the sexual offenses occurring in old age involve indecent exposure and touching or fondling children. A close examination of even these infrequent offenses suggests that their roots lie elsewhere than in sexual pathology. Many old men arrested for indecent exposure are simply confused and looking for a convenient place to urinate. Also, some old men have fantasies of youth and rejuvenation through contact with young children. In all these cases, sympathetic understanding seems more appropriate than punishment.

II
ORGANIC BRAIN DISORDERS

The second major group of mental disturbances among old people is called organic brain syndromes (OBS): impairment caused by deterioration of the brain tissue. The characteristic features of OBS disorders are impaired memory, poor judgment and intellectual functioning, confused orientation, and "inappropriate" emotional conditions. These disturbances may be very slight or very serious, requiring the older person's hospitalization. Some are reversible (acute brain syndrome) ; others are irreversible (chronic brain syndrome). The presence of OBS can be detected most easily by the old person's disorientation. He first becomes confused about time (day, hour, year), then about place ("Where am I?"). In advanced stages, the old person is unable to recognize other people or to remember his own name. Quite often, the older person will react to the decline of his mental abilities with a variety of compensatory and defensive reactions, including withdrawal, obsessive activity, and repetitious behavior. These reactions can complicate treatment, but they can also allow the old person to function adequately for relatively long periods of time.

Acute or Reversible Brain Syndromes

Reversible brain syndromes (RBS) are distortions in mental functioning caused by serious assaults on the brain. These assaults include strokes, alcoholism, infection, malnutrition, and injury. Reversible brain syndromes can be successfully treated if the illness or injury which causes them does not also kill the patient, as it often does. Symptoms of RBS include fluctuating levels of awareness ranging from mild confusion to hallucinations and delirium, disorientation, impaired memory, behavior disorders, and sometimes paranoid reactions. It is often difficult to distinguish RBS from organic brain disease and from emotionally-based personality disorders. Quite frequently, an older person suffering from a treatable RBS will be diagnosed as hopelessly senile by physicians and family alike.

Two of the most frequent causes of RBS are congestive heart failure and strokes. Many cases of congestive heart failure among old people first come to doctors' attention as confused mental states. An old person who survives a stroke usually passes through a period of severe mental confusion before regaining normal abilities. Massive or repeated strokes cause permanent brain damage and often death.

Malnutrition, another major cause of RBS, is more common among old people than usually realized. Many elderly cannot eat well because they are poor, but even middle class and affluent elderly become malnourished for social and physical reasons. Living alone, they lack the motivation to prepare and sit down to eat an adequate meal. Loss of teeth may discourage them from eating, and physical disabilities may prevent them from shopping. Depression, anxiety, and other emotional problems often reduce appetite.

RBS may be caused by alcoholism and by reactions to drugs the old person may be taking for other conditions. The central nervous system grows progressively more sensitive to the action of drugs as the person ages. Malnourished old people and those with kidney problems and arteriosclerosis are particularly prone to overreaction to drugs. Cortisone, steroids, tranquilizers, and drugs used to combat Parkinson's disease and arthritis often cause mental confusion and sometimes psychotic behavior. Many older people are shocked by normal—but to them unexpected—side effects of drugs such as barbiturates and tranquilizers. Doctors should be careful to study the side effects of drugs and warn the older person what to expect.

If the older person survives the crisis that brings on reversible brain syndromes, he has a good chance of returning to normal life. However, the crisis is fatal in about 40 percent of cases involving older individuals. Sometimes the reversible disorder will disappear, only to reveal a more serious underlying chronic problem.

Chronic Brain Syndrome

Chronic brain syndromes (CBS) are those irreversible, eventually fatal, processes of mental deterioration which most term "senility." The symptoms of chronic brain syndromes are often indistinguishable from those of reversible brain disorders. These may include excessive memory loss, repetitiousness, reminiscing, slow thinking, distortion of facts, poor judgment, and distortion of vision and hearing. Chronic brain syndromes can also involve rigidity of opinions, paranoid reactions, violence, and demonstrations of great physical strength. These disorders are very disturbing to the old person and to his family.

In fact, medical science has only begun to distinguish among permanent brain damage, reversible disorders, and emotionally-based disturbances within the past 40 years. The characteristic symptoms which are popularly termed "senility" can actually be caused by a number of physical and emotional conditions, many of which can be cured. Even though irreversible senile psychosis cannot be cured, many of the physical symptoms as well as the emotional anguish that go with it can be treated successfully, sometimes leading to actual improvement in the person's functioning.

The major types of CBS are senile psychosis—the physiological deterioration of brain cells—and arteriosclerotic psychosis, or brain damage caused by impairment of the blood supply. Classic senile psychosis is characterized by a progressive decline in mental functioning, particularly after 80 years of age. Deterioration is steady and often very gradual; the person moves from a normal functioning to greater and greater mental impairment. For some reason, women seem more vulnerable to senile psychosis than men. Although women live longer than men, a man who survives into advanced old age is likely to be less impaired physically and mentally than a woman of the same age.

Senile psychosis is caused by the physical destruction of brain cells. The brain actually loses weight as cells atrophy and degenerate. The cause of senile psychosis is unknown. Some gerontologists think that senile brain disease is an acceleration of a normal aging process; others say it is something quite different from normal aging. Senile psychosis is eventually fatal. However, many old people can live with this condition for many years with the proper medical treatment and supportive physical and emotional environment.

Arteriosclerotic psychosis affects the individual somewhat differently. Here, the cause of the brain damage is known: blood supply to the brain is impaired as the blood vessels harden or as they narrow and close. While senile brain disease brings a steady decline, arteriosclerotic disease affects the individual in an erratic fashion. He may have a completely impaired memory one minute, then regain it completely the next. It also occurs earlier in life than senile brain disease—the average age of onset is 66—and it affects three times as many men as women.

Arteriosclerosis is closely related to heart trouble. Cardiologists are unsure about what causes narrowing of the arteries, but the traditional American diet rich in cholesterol and saturated fats is now thought to be a prime culprit. Heredity, smoking, environmental pollution, and lack of exercise are also factors in this disease. As with senile brain disease, brain cells destroyed by an inadequate blood supply cannot be replaced, but prompt and careful medical attention can prevent further damage after an initial attack. The old person suffering from this disease can benefit from psychotherapy, physical therapy, recreation, and other services.

As with most other physical problems unique to the elderly, senility and brain damage cannot be considered apart from the individual old person's social and emotional situation. Meticulous post-mortem studies of the diseased brains of old people have failed to demonstrate a correlation between behavior and the degree of brain damage. Some old people manage to function quite well while undergoing marked brain deterioration. Others experience massive mental and psychiatric disorder while their brains are only mildly diseased. Apparently, even "senility" depends on social and environmental, as well as biological, factors.

The perplexity of the medical scientists in this matter underlines an important theme of this book: our perspective on aging must encompass the total situation of old people. If we consider aging as solely a *biological*, or a *psychological*, or a *sociological* process we shall never understand it fully.

PART III

POLICIES AND PROGRAMS

CHAPTER 10

ECONOMIC SECURITY IN LATER LIFE

Probably every problem older Americans face is at least aggravated by inadequate and insecure income. While a secure financial position by no means assures a trouble-free old age, older people with adequate incomes at least have access to the free choices of housing, travel, recreation, medical care, and friendships which are associated with the middle-class American "good life." Those older people with insufficient incomes are caught in a demoralizing struggle against poverty and its multiple problems.

Financial need can lead directly to serious medical and social problems. To conserve his finances, an old person may visit his doctor less frequently, permitting "minor" complaints to develop into serious illnesses. He may sell his car, shop less, eat starchy but filling food, see less of his friends, and perhaps withdraw into a kind of aimless half-existence. The complaint of a retired English laborer, quoted by Simone de Beauvoir, illustrates the connection between money and morale: "I just sit staring at these four walls, that's all. Before, I used to go out with my mates on Saturday evening, or with my sons-in-law. I can't do that any more. I'm like a pauper. I haven't got a pound note in my pocket, not now, and I couldn't stand my round. Life's not worth living, once you're retired." While this complaint is notably bitter, few older Americans are free from the sense of diminished options the man expresses.

In an era where the annual rate of inflation has reached double-digit percentages, few middle-aged workers can escape anxiety as they consider the prospect of possibly 20 or more years in retirement. While public and private programs have substantially improved the financial situation of most older Americans, economic issues will continue to be primary concerns of older people in the years to come.

Recent Progress

These recent changes in the economic situation of older people deserve some close scrutiny. The last 10 years have seen a revolution of sorts in the finances of the later years. A decade ago, retirement from work was often an economic catastrophe: millions of older people became poor when they retired; millions of others entered a difficult struggle to keep out of poverty. Today, the outlook for financial security in retirement is significantly more hopeful. A substantial transfer of money from the young working population to the elderly retired population has considerably brightened what used to be a bleak situation.

The federal government has accomplished most of this transfer by amending, improving, and liberalizing the Social Security Act. In 1965, after a fierce political struggle, the Congress passed the Medicare amendments which established a system of medical insurance for Americans aged 65 and over. At the same time, the Congress established Medicaid, which provides medical assistance payments for the poor, many of whom are also old. Between 1965 and 1975, Congress has raised Social Security benefits by approximately 75 percent. Social Security benefits are now tied to a cost-of-living escalator clause, providing older people with some measure of protection against the staggering pace of inflation. Most recently, the elderly poor, along with the blind and disabled, benefited substantially from the establishment of the Supplemental Security Income (SSI) program. SSI, which went into effect at the start of 1974, replaced all state-administered Old Age Assistance programs, and put the elderly poor on a guaranteed annual income, financed directly from the general revenues of the U.S. Treasury.

None of these programs has been an unqualified success. Inflation has eaten up most of the Social Security benefit increases, leaving elderly people little better off in relative terms. Medicare and Medicaid exclude more than half of older people's medical expenses from coverage, and have contributed to a prodigious inflation in the cost of medical care. SSI is plagued by administrative problems, and has been widely criticized for its restrictive eligibility requirements. Nevertheless, these programs represent substantial accomplishment. They have especially benefited the elderly poor.

Another trend with somewhat more limited impact has been the growth of private pension systems. These were once available only to the most affluent workers, but today perhaps one-quarter of the work force is covered by some form of pension program. Congress recently enacted legislation establishing some minimum standards for existing pension programs. These regulations are designed to help alleviate some of their inequitable features.

Despite this progress, as many as five million older people—a quarter of the over-65 population—still live in poverty. Some 3.5 million old people are officially classified as poor by the Social Security Administration. There is also substantial hidden poverty among the elderly. About 1.3 million old people with incomes below poverty levels are not classified as poor because they live in households with other people. If the combined income of all the individuals in the household is above poverty levels, the Social Security Administration does not consider any individual in the household to be poor. Thus, an old person living with one of his children will not be considered poor, even if his personal income is below poverty levels and he pays for room, board, and all other expenses of living. Another large group of hidden elderly poor are those living in institutions. About half of the one million elderly living in nursing homes and other institutions are poor, but they do not appear in poverty statistics. When measuring poverty, it is important to note that the Social Security Administration's definition of poverty is very conservative. An elderly individual is classified as poor if his income falls below $2130 a year. A couple is poor if they receive less than $2690 annually.

I

INCOME TRENDS IN LATER LIFE

Income drops sharply at the time of retirement; as a group, retired people live on less than half of the income of those still working. For many old people, retirement strikes with something less than catastrophic impact. Many workers earn their highest salaries in the years immediately before retirement. Middle-aged people are usually more financially secure than young couples with young families. With proper financial planning, perhaps a majority of middle-aged people can make a reasonably smooth transition from the high-earning years of middle age into retirement. Nevertheless, the central economic fact of later life is the sharp drop in income that comes with retirement. Once retired, the older person is likely to remain retired. Few will ever again receive significant income from paid employment.

Thus, retirement jeopardizes the older person's financial security. An example of how unstable his position can become was provided in 1971 when the Senate Special Committee on Aging noted with alarm that the number of poor older people had actually *increased*—from 4.6 to 4.8 million—between 1968 and 1969. During the same year, the number of poor people under 65 *declined* by about 1.2 million. The situation soon improved. By 1973, "only" 3.5 million older people were considered poor, according to the Social Security Administration's conservative index of poverty. This figure still represents 16 percent of the total over-65 population. Apparently, the 1971 and 1972 increases in Social Security benefits lifted one million older people from poverty. But the statistic is sobering. While Social Security retirement benefits were in the process of a decade-long 75 percent increase, the number of poor elderly at one point actually rose.

The Senate Committee's dismay underlines an important trend in income in later life: financial security in later life deteriorates over time. An adequate income at the time of retirement is likely to become inadequate over the years. This happens because the older person relies for his financial security on relatively fixed sources of income—chiefly Social Security payments, private pensions, savings, SSI, and other limited programs. He therefore has a limited ability to cope with inflation, rising living standards, and diminishing assets. We shall discuss below some of these powerful economic forces which undermine the older person's income position.

Inflation

In the past decade, the older American's greatest economic enemy has been the rapid price inflation which began in the mid-1960s and has continued ever since. Between 1960 and 1970, prices of all consumer items on the Consumer Price Index increased by 33 percent; they have risen by a similar percentage in the first four years of the 1970s. Older people feel the impact of inflation strongly because the three major items of the average older person's budget—food, housing, and medical care—have felt inflationary pressures most strongly.

For example, costs associated with homeownership increased by 60 percent during the 1960s. (Most older people own their homes.) These items include maintenance and repairs (56 percent); property insurance (56 percent); and property taxes (more than 45 percent). Nationally, older people spend *eight percent of their income on property taxes—twice the* percentage of those still working. Of course, the property tax bite is much larger in some areas than in others.

Even though Medicare and Medicaid pay for much of the cost of older people's medical care, the tremendous inflation in medical costs in recent years has hurt older people badly. In fact, the latest figures indicate that Medicare reimburses only 43 percent of all medical expenses of older people—a percentage which is also steadily declining. Older people paid $404 per capita in out-of-pocket costs for their medical care during 1972. In terms of cash, this is more money than the average older person was paying before Medicare was enacted in 1965.

The rate of food price inflation has jumped dramatically in the 1970s. Older people spend proportionately more for food than younger people do, and need special foods for medical reasons. The cost of public transportation—which is used mainly by old people, adolescents, and the poor—jumped 75 percent during the 1960s. Of course, the old also bear a relatively heavier burden from the steep increase in gasoline prices which began during the winter of 1973-74.

Note the interrelatedness of these inflation-based problems. With the cost of public and private transportation increasingly prohibitive, old people are unable to reach the big suburban shopping centers where the bargains are. No wonder we can detect a note of rage in this letter to a newspaper written by an older woman: "Every time Social Security is raised and even before, grocery stores keep raising the prices, penny after penny. The Social Security recipients seem never to have enough money for the necessities of life."

Living Standards

That woman touched on the underlying problem in the economic position of older people: most are destined to become *relatively* poorer as the nation's living standards rise. At best, the increases in Social Security benefits have kept older people up with the pace of inflation. Those retirees who live chiefly on Social Security today have about as much buying power as retirees did 10 or 15 years ago, no more. But meanwhile, America has become much richer and the living standards of the working population have risen. Without jobs, older people have no way to share in the fruits of this wealth.

There is an aspect of inequality in this situation. Younger people now enjoying higher living standards are building on an economy which was created by people now retired. Yet unless retirees own stocks, variable annuities, or other securities, they have no way to share in the benefits of the increasing productivity which their work largely made possible. (Obviously, stocks and other securities offer no guaranteed hedge against inflation, as many investors have learned to their chagrin.) Unless public income maintenance programs incorporate some mechanisms to distribute more wealth equitably among all groups in the population, a significant number of older people will *always* be poor or near-poor as measured by an ever-rising "poverty line." In view of the trend toward ever-earlier retirement, the *percentage* of older people in this position may even increase. Economists call this phenomenon a trend toward relative economic deprivation. As economic growth and inflation wipe out the gains older people have made, their economic status will eventually deteriorate relative to the working population. At the same time, growth of private pension programs threatens to open an ever-widening gap between retired people who worked at jobs covered by pensions, and those who must rely solely on Social Security for their retirement income.

II

SOURCES OF INCOME

The two major sources of income for older Americans are earnings from work and Social Security benefits. Together, these account for more than half of the total income of all Americans aged 65 and over. However, these two sources are not of equal importance in the lives of the average older person. Only 17 percent of the over-65 population is still in the labor force. Many of these older workers are highly-paid professionals and executives, and their earnings account for a disproportionate share of the total income of the older population. With the trend toward compulsory retirement and early retirement, fewer older people remain in the work force. At the same time, Social Security is becoming more prominent. It now accounts for something more than one-third of the total of all older people's income, up from one-fourth a decade ago.

The next two most important income sources are money from personal assets and private pensions. Assets provide about 15 percent of the total. Yet much of this income goes to the relatively small number of older people who own securities or rental properties. The most common asset older people possess is equity in a home; in 1969 some 71 percent of nonfarm older families were homeowners. But equity in a home is not a liquid asset; it can be converted into cash only if the elderly homeowner is prepared to sell and move, as most are not. Excluding home equity from the accounting, more than half of all older people have less than $1,000 in assets, mostly in the form of savings, bonds, and automobiles.

The percentage of older people receiving private pensions is steadily increasing, from 12 percent in 1967 to an estimated 25 to 30 percent in 1980. However, private pension programs are encumbered with limitations. Contrary to the hopes of those who designed the Social Security system, private savings for retirement through pension programs is unlikely to ever serve as the foundation for financial security in retirement. In the first place, the growth of private pension programs appears to be slowing down. According to an authoritative study of private pensions conducted by James Schulz of Brandeis University for the Senate Special Committee on Aging, well over half of the work force will never be covered by a private pension program in the foreseeable future. Those retirees who do have pensions still do not have a hedge against inflation. The benefit level of most pensions is fixed long before the worker retires. Since pension benefits are seldom adjusted for inflation after retirement, the value of the average pension will be cut in half over the retiree's lifetime. Pensions are sexist as well. Only a few transfer benefits to the widow after the husband's death. Given a choice, most men will decline to protect their wives if such protection means a reduced benefit while the men are alive. Schulz cites studies of pension programs where men are given just such a choice: a reduced benefit after retirement in return for widow's protection. Between 80 and 90 percent of the men choose the higher benefit with no protection. Those women who are eligible for their own pensions usually lose all their credits if they leave the work force for a few years to raise children or return to school.

Too often the promise of a pension proves to be illusory. Many workers must spend a considerable number of years with a firm before they are eligible for its pension program. In most programs, an employee loses all his pension credits if he leaves for another job. If the business fails, the workers are likely to collect no pension at all. Those who are pressing for tighter governmental regulations of private pension programs cite figures suggesting that only half of all workers who pay into a pension program ever receive any benefits from it. One federal official summed it up this way: "If you remain in good health and stay with the same company until you are 65 years old, and if the company is still in business, and if your department has not been abolished, and if you have not been laid off for too long a period, and if there's enough money in the fund, and if that money has been prudently managed, you will get a pension." The recent enactment of federal legislation regulating private pension programs is a first step to correct some of these problems.

The SSI Program

The final income source of major importance to older Americans is the Supplemental Security Income program, which went into effect on January 1, 1974. At one stroke, SSI replaced all the state-administered assistance programs which provided welfare relief for the elderly poor, the blind, and the disabled. The new program, administered by the Social Security Administration, provides a guaranteed annual income of $1752 for an eligible individual and $2628 for eligible couples. Because SSI's eligibility rules are more liberal than most of the state programs it replaced, more than twice as many persons now receive SSI payments as previously received state welfare benefits. In all, SSI checks go to an estimated 6.2 million people. Among them are 4.6 million elderly—about one in every five Americans aged 65 and over.

An example of how SSI works for older people comes from these two hypothetical cases in a Southern state. In one case, a retired farm hand comes to the local Social Security office to apply for help. He has no income and, since he worked only for small farmers in the area, has no work "record" and is not eligible for Social Security benefits. Before SSI, the retired laborer would have been sent to the local welfare office, and there told he is eligible for a $80 monthly benefit, plus a $22 bonus in food stamps. Now, the man would apply for SSI at the Social Security office, and would begin receiving a $146 monthly benefit.

In the second case, a widow eligible for Social Security benefits because of her husband's work record comes to the Social Security office to apply for payments. Before SSI, she would have been entitled to perhaps $108 a month, as an example. Under SSI she would also be entitled to receive a $58 Supplemental Security Income check. She receives $20 a month more than the retired farm hand because, for purposes of computing benefits, SSI disregards the first $20 in Social Security benefits or other income being supplemented.

It is apparent from this example that SSI particularly serves old people like the retired farm hand—those elderly poor who live in poor, rural, mostly Southern states. These are states which have never paid welfare benefits as high as the richer Northern and Western states. At the same time, SSI assures that no older person will receive less in SSI benefits than he previously received from more generous welfare programs in such "high benefit" states as California and New York.

SSI has doubled the number of elderly, blind, and disabled people eligible for assistance. It has accomplished this by defining poverty more generously than many states had done, and by liberalizing restrictive requirements most states imposed on applicants as a condition of assistance. These included regulations which often forced an older person to exhaust all his financial resources before he could be eligible for Old Age Assistance, allowed the state to seize the recipient's property after death as reimbursement for the cost of welfare, and required children to contribute to the support of elderly parents. The difference between SSI and welfare is one of attitude. SSI guarantees a minimum income to elderly poor, blind, and disabled people as a matter of right. Its thrust is to put money in the pockets of as many elderly poor, blind, and disabled as possible. The thrust of categorical welfare programs is in the opposite direction; they operate to restrict benefits and to keep the welfare rolls as small as possible.

For all its promise and genuine accomplishment, the implementation of SSI has had more than its share of troubles. In testimony before the Senate Special Committee on Aging, James A. Bensfield of the National Senior Citizens Law Center described a variety of problems flowing both from the program's newness and from restrictive bureaucratic interpretation of Congressional legislation. The administrative problems are predictable, while no less damaging to needy people who rely on the monthly arrival of their SSI check. The administrative mechanism of SSI is a centralized data processing system which must deal with complex calculations for 6 million individuals, taking into consideration 50 state variations for supplementation, Medicaid eligibility, and other criteria. Mistakes are an unfortunate by-product of such complex centralization. But as one Social Security official put it: "We might have three million cases to worry about, but for the guy out there waiting for his check, his case is the only one he's got."

To remedy the situation, Social Security officials are working to improve the computer system. In the meantime, the Social Security Administration has expanded emergency check-issuing authority and implemented a more flexible procedure to replace benefits which, for some reason, do not arrive.

But alteration of other Social Security Administration procedures will require new policy interpretations or new legislation. The Congressional statute authorizing SSI instructed the Social Security Administration to consider disabled persons "presumptively eligible" while their claims are being processed. The Social Security Administration has interpreted this requirement as meaning only amputees and totally deaf people. Other restrictions have drawn fire from civil libertarians. For example, alcoholics and drug addicts are required to have their SSI benefits paid to a guardian, regardless of the recipients' ability to manage their own affairs.

Narrow restrictions which affect older people more directly involve the areas of income and personal resources. SSI payments are automatically reduced by one-third if the recipient is living in a household headed by someone else, even if the recipient pays for his room and board. Another regulation sets a limit of $25,000 on the market value of a house which a person may own and still be eligible for SSI. This regulation does not take into account regional variations in market value of homes, nor does it consider the homeowner's equity. Thus, Mr. A could have only $4,000 equity in a $30,000 home while Mr. B could own a $23,000 home outright. But Mr. B would be eligible for SSI while Mr. A, the man with fewer resources, would be excluded.

On balance, SSI's impact as a weapon against old age poverty is more potential than actual. Its annual benefit level of $1,752 for individuals and $2,628 for couples will allow few people to live securely. The administrative problems and remaining eligibility restrictions remain to be worked out. The promise of SSI lies in basing aid to the needy on the resources of the U.S. Treasury rather than state revenues, and transferring basic decisions about benefits and eligibility from state governors and legislators to the President and the U.S. Congress. The hope is that the federal decisionmakers will be more likely than state officials to raise the SSI benefit level to accommodate both inflation and changing legislative and social perceptions of poverty. Some officials predict that, if all goes well, the combination of SSI and higher Social Security benefits can abolish poverty among the older population entirely.

Other Income Sources

Other sources of post-retirement income are either declining in importance or are remaining steady. Money from veterans' benefits, civil service pensions, railroad retirement, and other public sources has remained at about 10 percent of the total over the past decade. Contrary to popular belief, cash support for older people from their children is the smallest and least important source of income after 65. It is estimated that only one percent of the total of older people's income comes from personal contributions from children, friends, and other sources. Of course children indirectly support their parents through the Social Security system which transfers money from the working population to the older retired population.

III
SOCIAL SECURITY: FUTURE DIRECTIONS

The cornerstone of economic security in later life is the Social Security system. Some 91 percent of all Americans aged 65 and over are eligible to receive Social Security retirement benefits. Most of the remaining 9 percent are eligible for SSI payments. Most of the recent improvements in older people's economic position flow from liberalization of Social Security. These improvements include Medicare, Medicaid, SSI, and a 75 percent increase in retirement benefits. Yet these recent gains leave much room for further advances. Older people pay more in out-of-pocket expenses for medical care today than they did 10 years ago—despite Medicare and Medicaid. The annual income which SSI guarantees to the elderly poor, and to the blind and disabled, is quite low, and the program is plagued by administrative problems and by restrictive interpretations of eligibility regulations. The 75 percent hike in Social Security retirement benefits has shared in the general attrition of income through inflation.

Nevertheless, future gains in older people's economic security depend almost entirely on further improvements in the Social Security system. The system is already so well established in the lives of older people and in our economic system that to scrap it in favor of something else would be exceedingly difficult. Some radical economists propose substituting a sweeping, non-contributory guaranteed minimum income plan for Social Security. Some conservatives favor a system which relies totally on private savings and insurance. Neither alternative appears feasible. Neither do other sources of income available to older people appear to offer a serious alternative. Pensions, savings, earnings from employment, and investment income will provide significant income to only a minority of those who will be retiring in the next 40 to 50 years. On balance, only Social Security has the flexibility, resources, and political support necessary to bring about significant economic changes in the lives of large numbers of older people.

The importance of Social Security is being increasingly recognized just as the system is coming under its harshest criticism since its inception in 1935. In those days, some Congressmen and legal scholars doubted that the federal government had the constitutional authority to compel Americans to join a system of compulsory social insurance. Until the Supreme Court upheld Social Security in 1937, the constitutionality of the system was doubtful. Today, the questions are broader. Critics question Social Security's benefit levels, its financing structure, long-term fiscal soundness, and various restrictive provisions. Some of the criticism is vicious and irresponsible. Many critics are fundamentally confused about the difference between a system of *social* insurance such as Social Security and a system of *private* insurance, a confusion for which the Social Security Administration itself bears a measure of responsibility. The sheer volume of recent criticism is probably attributable in large part to the unpleasant fact that Social Security payroll taxes are taking a larger bite out of everyone's paycheck. Nevertheless, many of the questions about the system are thoughtful and serious. The economic security of future older Americans depends on careful changes in response to these questions.

Social Insurance

To understand the current debate, we must return to the historical foundation of the system as it was laid during the bleak years of the Great Depression. To win Social Security's passage by the Congress and its eventual approval by a Supreme Court that had been overturning New Deal legislation, the architects of the system made some basic decisions. To deal with the problem of financial security in retirement, they designed a contributory wage-related plan paying variable benefits according to the employee's record of earnings. The system was to be financed by payments from both the employee and his employer. This plan emphasized personal responsibility and incentive. Employees had to contribute toward their own retirement benefits. Employers had to contribute toward the security of their workers. Benefits varied according to history of earnings. These benefits were supposed to provide a basic floor of protection in old age, not total economic security. Thus, Social Security emphasized reward for hard work, high earnings, and high productivity. The system's architects rejected several alternatives, including a flat payment to all older people from the general revenues of the Treasury, a welfare program serving all elderly who fell below a given level of income, and a compulsory savings program.

Social Security, then, is a government-operated social insurance program which now covers almost all Americans against certain specified risks. It protects widows and children against loss of income if the breadwinner dies. It protects workers and their families against the financial setback from disability. It protects workers, their spouses, and their widows and widowers against the loss of income caused by retirement. The essence of insurance is a spreading of risks. Some people will receive more in benefits than they pay in. Some will break even. Some will pay more into the plan than they receive. Social Security is in no way a "savings" program, in which everyone always receives more than he contributed.

Much of the criticism of Social Security stems from a misunderstanding of the insurance principle. A single worker who dies just before retirement after paying the maximum contribution to Social Security since 1937 will lose everything—a total of $8,352. But if the worker has a wife and if they both live a normal number of years after retirement, they will receive about 10 times the amount they paid in—some $80,000. Those who live longer than normal lives will receive correspondingly more in benefits.

If one mistakenly views Social Security as a savings plan, it is easy to come up with a freak example to show inequity. For example, the widow of a 23-year-old worker who paid $676 to Social Security before his death will receive $300. On the other hand, if the widow has permanently disabled twin children, it is possible for the three of them to receive $1.8 million from Social Security over their lifetimes. Neither example is typical. One cannot judge the equity of the system on the basis of such instances. Rather, we must examine the overall impact of the system to make a fair judgment.

On balance, the system does very well. A system of social insurance such as Social Security does a much better job than private insurance plans because its compulsory nature and government administration make unique economies possible. Since Social Security is compulsory, risks can be spread to the widest possible extent, thus lowering the cost of protection. These savings allow the federal government to administer the program for about two percent of the total tax income. Since Social Security tax revenue draws about 5.6 percent interest annually, more than 103 percent of all Social Security taxes is paid out in benefits each year. In comparison, the private life insurance industry returns about 85 percent of premium income in the form of benefits. Other segments of the insurance industry return less. Says Richard E. Johnson, an insurance economist: "Even though the life insurance industry is doing a great job in comparison to the rest of the insurance industry, the Social Security Administration is doing a phenomenal one, almost beyond belief for a government agency."

A social insurance system such as Social Security also operates on different actuarial rules than private insurance plans. By law, private insurance trust funds must contain enough money to pay all current outstanding obligations. The law does not allow private insurers to assume that any more people will sign up for their plans in the future. If Social Security were subject to the same requirements, its trust fund would have to contain between $500 billion and $1 trillion. Actually, Social Security's trust fund contains about $50 billion, or enough to pay about one years' benefits. During each year, it receives enough in tax revenue from employees and their employers to pay the next year's obligations. Many critics have called this pay-as-you-go system "bankrupt." However, the compulsory nature of Social Security allows its actuaries to count on continuing additional income from new workers coming into the system, according to projections of population and economic growth.

A compulsory system of social insurance which operates on a pay-as-you-go basis can operate more efficiently, flexibly, and generously than private insurance programs. It has permitted the Congress to steadily expand the system to cover individuals whom private insurance companies would consider unacceptable risks—including migrant workers, domestics, widows and widowers, the unemployed, the disabled, the blind, the ill, and the poorest of the poor. With the advent of SSI, Social Security coverage is now nearly universal, with poor risks and good risks all enjoying one umbrella of protection. Further, Social Security offers its 30 million beneficiaries protection against inflation through an automatic cost-of-living escalator clause. This is something no private insurance plan can do.

Nevertheless, much confusion about the nature of Social Security persists among the public and even some economists. Many people consider the money they pay in Social Security payroll taxes as "their" money, lying in a trust fund, to be recovered at a later date. They view Social Security as something like endowment life insurance, which pays a flat settlement in case of death before a certain age and then a monthly stipend thereafter. This comparison is false. Social Security is low-cost insurance, not a quasi-savings plan. Nevertheless, this misleading comparison persists. It is the source of the frequent criticisms of Social Security which "demonstrate" how a young worker could buy better protection from a private insurer than Social Security could give him. For this misconception, the Social Security Administration itself is partially responsible. Consider this description of the system from a booklet published by the Department of Health, Education, and Welfare:

> The basic idea of Social Security is a simple one: during working years, employees, their employers, and self-employed people pay Social Security contributions which are pooled in special trust funds. When earnings stop or are reduced because the worker retires, dies, or becomes disabled, monthly cash benefits are paid to replace part of the earnings the family has lost.

"Special trust funds" used in this sense is subtly misleading. When he retires or becomes disabled, a worker does not draw on his own money, along with the interest that has accrued. Nor do widows and dependent children draw on the deceased worker's money in the event of his death. All Social Security benefits are paid from tax monies currently pouring in from workers still in the labor force and their employers. Older people living on Social Security today are not receiving "their" money, but money being paid into the system by younger workers.

An Agreement Among Generations

Contrary to common belief, Social Security is a massive mechanism to transfer money from the working to the non-working population. This fact is a two-edged sword. It strips away misconceptions and helps us understand the nature of the system. But it also uncovers one of the most disturbing problems about the future.

The difficulty lies in the hidden intergenerational agreement which Social Security has come to represent. Through their Social Security taxes, people now working are supporting about 30 million retired and disabled Americans, their dependents, and the dependents of deceased workers. The level of benefits these individuals receive typically bears little relationship to the amount of taxes *they* paid into the system while they were working. A man and wife who retire today at age 65 and live a normal number of years will receive about 10 times more in Social Security benefits than they paid in taxes. Some of the system's generosity flows from its nature. As a program of compulsory social insurance, it can afford to be much more generous than any private insurance or annuity plan.

However, Social Security is generous to its beneficiaries because Congress has steadily raised benefit levels. To finance these benefits, Congress has raised taxes as well. In 1935, the most any worker could pay into the system was $30. Today, the maximum tax is $772. Social Security taxes have risen 800 percent in the past 20 years. However, the growth of the labor force and the economy have permitted a 1000 percent increase in benefits over the same period.

The problem comes when we consider these demographic trends which have absorbed so much of the Social Security tax bite. Workers today pay much more in Social Security taxes than their parents did. But the increase would have been much steeper if the labor force had not been expanding at its fastest pace since the early 1900s, as the children of the post-war baby boom come to work. With so many new workers to tax, Congress has been able to increase the average amount paid to each beneficiary at a faster rate than the increase in Social Security taxes.

But what happens when the post-war babies—the largest age cohort in American history—begin to retire? The post-war generation is also having fewer children than any generation in American history. Thus, the first part of the 21st century offers the prospect of a vastly larger group of retirees needing Social Security benefits and, to pay these benefits, a work force which is growing slowly, if at all. Today, there are 3.2 workers for every person receiving Social Security. Projections indicate that there will be only 2.2 workers for every recipient in 2025.

This situation presents future Presidents and Congresses with three options. Two are unpleasant and one is probably politically impossible. The impossible option is to reduce Social Security benefits for future retirees, disabled workers, their dependents, and other beneficiaries. Such a benefit reduction would keep Social Security taxes from rising, but would also outrage most Americans, and create a larger population of poor people who would have to be cared for somehow. Probably no elected official who faces the voters would dare to seriously propose such a step. Instead, politicians are more likely to choose either of two other options, both of which involve higher taxes.

The first alternative is to raise the level of employee and employer payments into the system to support an increasing benefit level. This could be done by raising the tax rate—currently 5.85 percent—or the ceiling on taxable income—now $13,200. Of course, both the tax rate and the income ceiling could be raised, as they have been regularly since Social Security began. Some authorities have suggested a variation of this alternative: to replace the current regressive method of Social Security taxation with a progressive system requiring those with higher incomes to pay more. All suggestions under this alternative amount to requiring workers and their employers to pay a higher price for Social Security protection.

Obviously, such measures carry their own political dangers. The recent rather swift rise in Social Security taxes has caused a rumble of protest, and accounts for much of the current criticism of the system. However, some economists, including James Schulz of Brandeis University, predict that American workers will pay with less grumbling than might be expected. He says that Western European work forces, decimated by World War II, have routinely paid rapidly rising taxes to support older populations which are growing faster than the labor forces. Many younger people do not complain about Social Security taxes because they view them as an indirect way for children to discharge their ancient obligation to support their parents in their old age.

Nevertheless, elected officials may choose to avoid higher Social Security payroll taxes by choosing a second alternative: subsidizing the system with direct appropriations from the U.S. Treasury. Such subsidies would tend to sever the link between contributions and benefits, but would also introduce a new and badly needed source of money into the system. Of course, general revenue subsidies would also involve higher taxes.

We turn to a more detailed discussion of some of the major proposals for financing reform.

Proposals For Financing Reform

The entire subject of the financing of Social Security is now being examined by the Advisory Council to the Social Security Administration. It expects to make recommendations to the Congress in 1974, with legislation changing Social Security's tax structure a possibility by 1975.

The Advisory Council's recommendations may well change perhaps the most controversial aspect of Social Security's financing—the regressive nature of the payroll tax. Since its inception, Social Security has been financed by a uniform tax rate levied on a certain portion of the worker's income. This sum is then matched by the individual's employer. The regressive impact of this tax was largely hidden during the program's first years. In 1935, the basic Social Security payroll tax was one percent, and it applied to the first $3,000 of annual earned income. Some 95 percent of all workers were making $3,000 or less and thus paid the maximum contribution of $30. By 1974, the Social Security tax rate had risen to 5.85 percent, and it applied to the first $13,200 of earned income. But today, one in four workers earns more than $13,200. This fortunate quarter of the work force gets a tax break. For example, a person earning $26,400 pays the same $772 into the system as another earning $13,200. But the higher-salaried worker is paying only half the percentage of his income in Social Security taxes that his lower-paid counterpart pays. For 95 percent of all workers to have their wages fully covered in 1974—the same proportion as when Social Security began—the wage ceiling would have to be raised to $19,200.

The architects of Social Security chose this method of taxation for two major reasons. First, and most pragmatically, they had to design a system that would win the approval of a fiscally conservative Congress. President Roosevelt's policy-makers felt that Congress would balk at proposals to raise income taxes and finance Social Security from the general revenues of the U.S. Treasury. The second reason for their choice was a psychological gambit aimed at the public. Social Security's designers wanted to build a sense of entitlement into the system. They wanted Americans to feel that the power and resources of the U.S. Government were behind the system, promising Americans "their" benefits if they retired, became disabled, or if the breadwinner died prematurely.

This feeling is essentially a piece of folklore. The system works on a pay-as-you-go basis, with current benefits being paid from current receipts. Through Social Security, workers support those who cannot work. Yet this sense of entitlement is of crucial importance. The actual effect of Social Security—a transfer of money from workers to non-workers—sounds suspiciously like welfare. And Social Security would in fact operate like a massive welfare program if it abandoned payroll taxes and relied solely on higher personal and corporate income taxes to finance its payments. By building a sense of "a stake in the system" through personal payroll taxes, Social Security largely avoids the welfare stigma plaguing other programs that support the poor and those who are likely to be poor. Largely because of this subtle psychology, Social Security enjoys a unique measure of political support.

Nevertheless, a strong case can be made for modifying the payroll tax to eliminate some of its more regressive features. The strongest case is made by those who deplore a regressive tax's negative impact on the poor. The 15 million American "working poor," including many of the older people who work, pay 5.85 percent of their income for Social Security taxes, just like anyone else who makes $13,200 a year or less. They pay this tax even though their taxable income is too low to require them to pay personal income taxes. Thus, the Social Security payroll tax hits poor people harder than anyone else. For many, it represents a major reduction in their income. Also, poor people, and especially the minority poor, die sooner and are less likely to enjoy Social Security retirement benefits. For these reasons, many authorities have proposed returning Social Security taxes to the poor through a government refund—a version of the negative income tax. This measure would make Social Security an even more effective anti-poverty weapon than it is now. Without Social Security, between 12.5 and 15 million Americans would be living in poverty.

Broader proposals to reform the financing provisions of Social Security frequently include enlarging the general revenue subsidy of the system. The essential issue is whether the payroll tax—a regressive levy—should be used to assume the total burden of coverage of the least advantaged. Already, the "pure" design of Social Security as a system tying benefits strictly to the individual's record of earnings from employment has been significantly altered. People with the poorest record of earnings receive more in benefits than their work record would strictly entitle them to. When benefits are raised, a slightly disproportionate share usually goes to those receiving minimum payments. Also, both SSI and Medicare entitle poor people to coverage, regardless of their record of earnings. Thus, the U.S. Government is already a third-party contributor to the system. The issue is whether these general revenue contributions should be enlarged and made permanent.

A recommended approach might be to continue the payroll tax, but to increase the system's reliance on a general revenue subsidy. The payroll tax would help people feel that they have a stake in the system. The general fund subsidy would reduce the system's reliance on regressive taxation by introducing the dynamic element of progressively-raised revenues.

Restrictive Provisions

One of the most controversial aspects of Social Security is the so-called retirement test—the allowable amount of income a worker between the ages of 65 and 72 can earn without losing Social Security benefits. The retirement test reduces Social Security payments by $.50 for every $1.00 earned over $2,400 a year. For example, a semi-retired man eligible for the maximum benefit would receive $399 monthly if he earned no more than $200 a month from employment. If he earns $300 a month, his Social Security would be reduced by $50. If he earns $400 a month, payments drop by $100, and so forth. Of course, this "extra" income is subject to Social Security taxes as well as personal income taxes. The overall effect of the retirement test is to keep retired people retired. Of the 22 million older people eligible for retirement benefits, only 6.4 percent have their payments reduced because they earn more than $2,400 a year.

Opponents of the retirement test decry its discriminatory nature: income from stocks, savings, annuities, and other invested funds is not penalized. Only those who draw a paycheck suffer. Since 3.5 million older people are poor, they argue, any measure which discourages work is unjustified.

Defenders of the retirement test say that it frees Social Security revenues for those who really need them—the poor, the disabled, and others who cannot find work. To repeal the income test would cost an additional $4 billion annually. This sum would have to be raised by higher taxes, and most of it might go to professionals and other white-collar workers who do not rely on Social Security for the basis of their retirement income.

However, many Congressmen and economists are moving toward substituting an "adequacy" test for the retirement test. This proposal would allow older people who "can't afford to retire" to supplement their Social Security benefits through paid employment up to an "adequate" standard of living. Beyond this level, benefits would be reduced. Definitions of "adequacy" vary considerably, but most authorities accept the Bureau of Labor Statistics figure of about $5,000 as the amount a retired couple needs to live modestly but adequately.

Finally, many critics of Social Security are looking dubiously at several provisions which discriminate on the basis of sex. Currently, the system does not recognize household work as covered employment. Women cannot obtain entitlement to their own benefits unless they draw a paycheck. For women who do work, their record of earnings from employment suffers if they interrupt their working careers to return to the home and raise children. (These provisions apply equally to the small but apparently growing group of male homemakers.) Another sexist provision discriminates against men: widows and wives are eligible for their husbands' benefits, but widowers and husbands are not eligible for their wives' benefits.

IV

SPECIAL ECONOMIC NEEDS

Current demographic trends and past social injustice have created several groups of older people who need special economic consideration. Here, we shall briefly discuss the special income needs of minorities, women, and the very old.

Minorities. While the social situations of aged blacks, Spanish-speaking, Asian Americans, Indians and other minorities vary considerably, their financial status is uniformly bleak. In 1969, one-fourth of the black families with an older man at the head lived on annual incomes under $2,000. Only one-tenth of similar elderly white families lived so poorly. The situation for elderly blacks living alone is even more dismal. In 1969 more than three-fourths had incomes of less than $2,000; one-third lived on less than $1,000. White elderly living alone have almost twice as much to spend.

The income situation for elderly Mexican-Americans is similar. Indians appear to be the poorest of all. Though data is scarce, it indicates that most old Indians live on less than $800 a year.

Many of these minority elderly are not eligible for Social Security benefits. Domestic and farm laborers have only recently been included in the system, leaving out millions of today's minority elderly who worked in these jobs while younger. Most old Indians worked only sporadically while young. On many reservations, including some of the largest, more than half the labor force is unemployed at any one time.

Women. Much of the problem of income maintenance among the elderly involves the increasing numbers of older women. Because women live longer than men and because men tend to marry women younger than themselves, most women are widowed by age 70. A majority of men are not widowers until after age 85. By 1980, older women will outnumber older men by about three to two. Old women have fewer income resources than old men. They seldom have pensions or the chance for meaningful income from work.

The Aged. As the American population has grown older, the older population itself has grown older. In 1930, only 29 percent of persons 65 and over were in the over-75 group; today, about 38 percent of the older population are in this "aged" group. Further, the percentage of very old people—those aged 85 and over—is also growing. The percentage of very old has risen from 5.6 percent of the over-65 group in 1960 to about 6.7 percent today. The figure is projected to reach 7.6 percent in 1980, or about 1.8 million people. These aged are the poorest and neediest of all. The fact that most of the aged are also women only underlines the magnitude of their income needs.

CHAPTER 11

HEALTH CARE

Physiological aging is a series of processes which gradually renders the human body less resilient and less adaptable to stress. Psychological aging, while more complex than commonly believed, has the similar effect of slowing the older individual's reaction time, blunting the acuity of his senses, and reducing the mental margin for error. At the same time, the social processes of aging present the individual with a series of important challenges. Widowhood, retirement, bereavement, economic insecurity, and the consequent need to make many small and large adjustments place the older individual in those situations of stress to which he has become less adaptable.

The nature of these interrelated processes of aging is reflected in older people's health care needs. These needs are substantially different from the health care requirements of other segments of the population. The major medical challenge for older people is to learn to live with debilitating, chronic illness. Their needs for mental health treatment are largely neglected, even though older people constitute nearly a third of all patients in public mental hospitals. The elderly as a group are also more likely to be malnourished, and they face an additional problem which is almost entirely their own—the lack of high-quality nursing homes and other long-term care facilities.

Worries about health and the cost of health care rank at the top of most surveys of older people's opinions about their needs and problems. Anyone who has worked with older people has heard many versions of this remark: "I've got a lot I want to do, and I think I have enough to live on. If only my health holds up..."

The issues involved in supplying health care to the elderly are thus of vital importance to America's older people and to those who serve them. We shall discuss some of these issues in this chapter. It is divided into four sections: physical health, mental health, institutional care, and nutrition.

I
PHYSICAL HEALTH

The treatment and management of chronic illness are the major medical problems of American elderly. About four older people in every five are afflicted to some degree by one or more chronic conditions. Chronic conditions are those which are either permanent, leave residual disability, or require long periods of rehabilitation and care. The leading chronic conditions among old people are arthritis and rheumatism, followed by heart disease, high blood pressure, asthma and hayfever, diabetes, chronic bronchitis, and ulcers. Other chronic conditions often afflicting older people include impairment of vision and hearing, paralysis, and permanent stiffness in joints.

These chronic medical problems merely irritate some old people; they lead relatively normal lives despite aches and pains and other complaints. However, chronic illnesses significantly limit the activities of about half of all Americans aged 65 and over. They prevent nearly one older person in five from carrying out basic activities of daily life, such as cooking and climbing stairs. The severity of these disabilities increases dramatically with age. Between ages 65 and 74, 40 percent experience some significant disability. Above age 75, the prevalence of disability rises to 60 percent. Vision and hearing loss are particularly common among the oldest of the old. Those over age 75 suffer impairment of these senses at rates two and three times those of people aged 65 to 74.

On the other hand, older people are less often afflicted with acute illness—conditions lasting less than three months—and they are less likely to be injured than younger people. However, acute illness and injuries are more serious when they do strike old people. People aged 65 and over take about twice as long to recuperate from an acute illness as those aged 45 to 64. Similarly, older people lose twice as much time recuperating from injuries, even though older people are about half as likely as others to be injured. Half of older people's injuries occur in home accidents—three times the national average.

In all cases, older people with low incomes have more health problems and higher rates of disability and injury than those with high incomes.

The Management of Chronic Illness

One of the most pressing challenges facing older people and their families is the problem of managing the crises, symptoms, and treatment regimens of chronic illness. This challenge is only partly a medical matter. In fact, medical understanding of the causes, symptomatology, and treatment of chronic illness is probably much further advanced than our understanding of the *social* factors involved in living with conditions which can be treated but not cured. Among the most important of these problems of living are arrangements to prevent medical crises, to control symptoms, to organize one's time efficiently, to prevent or cope with social isolation, and to normalize the routine of daily life despite the disease. Despite our rudimentary understanding of these socio-medical problems, older people do in fact adopt basic strategies to solve them, usually in concert with friends, family, and health professionals.

Of particular importance are the social adjustments required to control the symptoms of chronic disease. Emphysema patients learn to have "puffing stations" where they can regain their breath while looking like they have stopped normally. Heart patients may move to a one-story home. Arthritics arrange furniture for maximum convenience, and alter their schedules to compensate for their limitations. Says social psychologist Anselm Strauss: "the chief business of a chronically ill person is not just to stay alive or to keep his symptoms under control, but to live as normally as possible despite his symptoms and his disease."

Many older people fail at this business of living as normally as possible. Some are afflicted with diseases which are simply too serious and demanding to accommodate within a daily household routine. These older people enter nursing homes and other institutions providing constant care. Others may give up their treatment programs. But many other old people succumb to the limitations of chronic illness because they lack the judgment or the assistance to make necessary adjustments. Without adequate personal and social resources, the arthritic, the heart patient, the partially blind older person may sink into miserable isolation, either self-imposed, or imposed by the circumstances of his social situation. To manage his illness, the older person needs to solve social as well as medical problems.

The Cost of Medical Care

Medicare works reasonably well for an older person stricken with an acute illness requiring a fairly short stay in a hospital. For a 12-day hospital stay and a medical bill of about $500, Medicare will cover about 75 percent or even more of the older person's total cost. However, Medicare works less well in a more typical case—when the older person is afflicted with a long-term chronic illness. On the average, Medicare pays only about two-fifths of each older person's average annual medical care bill of $1044. The percentage of old people's medical care costs reimbursed by Medicare has actually declined a few percentage points each year since 1969. Despite the fanfare marking the passage of Medicare in 1965, the rising cost of medical treatment remains perhaps the greatest barrier to better medical care for the elderly.

The cost problem is relatively simple to explain. First, more than half the expenditures older people make for medical care are simply excluded from the Medicare program. These include prescription drugs, dental care, eyeglasses, hearing aids, foot and eye care, most home health service, long-term care in nursing homes without prior hospitalization, and most psychiatric care. Second, the fees and deductibles older people are required to pay under Medicare have doubled since the program began. These items have been and remain sizeable portions of the older person's budget. Finally, the medical costs older people must pay have been escalating rapidly. Between 1967 and the fall of 1973, all medical costs rose 38 percent. The charge for a semiprivate hospital room rose 82 percent; operating room charges rose 79 percent; and physicians' fees rose by more than a third. The long-range trend is even more startling. Total expenditures for health care increased by 500 percent in the 20 years between 1950 and 1970. Between 1960 and 1970, hospital costs alone rose 500 percent. Medical costs in general have been increasing twice as fast as the cost of living.

Medicare and Medicaid, the medical insurance programs older people rely on most, bear some responsibility for this inflation in health care costs. By relieving some of the financial burden of health care, Medicare and Medicaid made medical services readily available to the elderly and the poor. In the classic economic equation, sharply higher demand for a relatively static supply of services caused sharply higher costs. The supply of medical services, especially trained medical personnel, has not expanded nearly as fast as has the demand for service. At the same time, Medicare and Medicaid fostered distortions in the system of medical services which work to the disadvantage of older people. Those parts of the system covered by Medicare have benefited: chiefly, acute hospital care and private physicians' fees. Those parts of the system not covered have languished. These include long-term care, rehabilitation, and home health care—the areas of older people's greatest needs.

Despite the federal government's $12.1 billion expenditure for Medicare in the fiscal year ending in 1974, the cost of the program to the consumer is still considerable. Under the hospital insurance part of Medicare (Part A) the older person must pay the first $84 of the cost of his hospital stay, plus the first $21 of the daily cost from the 61st to the 90th days. Part A will also pay only a part of the older person's stay in a skilled nursing facility *if* the patient has first been hospitalized for three days. This provision for long-term care has become one of the most troublesome and costly aspects of the program. Many skilled nursing homes will not accept Medicare patients because of delays in reimbursement and confusion in the rules. As a result, old people often spend many needless and costly days in the hospital waiting for a nursing home bed to become free. A study at Massachusetts General Hospital in 1969 showed that these "day delays" cost $60,000 in one month. This cost is borne by patients, hospitals, and the Medicare program itself.

Similar problems plague the medical insurance section of Medicare (Part B). This program covers physicians' services, ambulance services, prosthetic devices, and certain outpatient hospital services such as x-rays, laboratory tests, radiation therapy, and some physical therapy. To join Part B, an older person must pay $80.40 a year in premiums. He must also pay the first $60.00 in claims each year and 20 percent of the remaining costs. In addition, because of paperwork and delays in reimbursement, more than half the physicians in the United States refuse to accept Medicare patients. Finally, Medicare may refuse to pay physicians' charges which are not "reasonable" according to Medicare guidelines. In these cases, the older person must make up the difference between the doctor's bill and that portion of it which Medicare is willing to pay.

Federal policy-makers and advocates for the elderly have been considering several measures to control the costs of medical care in old age. Most of these proposals are controversial. The 1972 Social Security Amendments directed the establishment of Professional Standards Review Organizations, bodies of licensed physicians which will scrutinize the quality and operation of medical facilities in a locality. PSROs, while not involved directly in questions of costs and fees, could substantially affect costs by directing more efficient use of medical facilities. The American Medical Association has opposed the establishment of PSROs, arguing that they represent unjustified government interference in the private practice of medicine.

Organized medicine also largely opposes proposals for fixed fee schedules and regulations requiring all physicians to take Medicare patients. Some authorities also argue that the Social Security Administration should take over the operation of the Medicare and Medicaid programs, a function now performed by private insurance companies. These and other issues need solution as the Congress moves toward passage of a national health insurance program. A comprehensive health insurance program would benefit older people by expanding the coverage they already enjoy under Medicare, and perhaps by fostering greater coordination and efficiency in the system of medical services.

Other Barriers to Health Care

The System. The American system of health care is not well suited to meet the particular medical needs of older people. The system is strongest when it serves sick people for relatively short periods of time in acute care hospitals. Here, the full range of modern medical technology and expertise can be brought to bear most effectively. However, older people suffer less frequently from acute illnesses. Their greatest needs occur in the areas where our medical system is weakest: the treatment of chronic disease, rehabilitation, preventive medicine, long-term care, and home health care.

A major weakness of the American health care system is its piecemeal nature. Some critics call it a "nonsystem." Ideally, a well-organized health care system would consist of a comprehensive and well-coordinated continuum of services. It would flow from health education, diagnostic screening, and other preventive measures, through acute hospital care, to flexible measures to rehabilitate older patients and to maintain those who are chronically ill. However, these vital services are provided erratically in this country—especially rehabilitation and chronic care. They are often only available to those with ample financial resources for private services. A coordinated health care system would benefit everyone, but it is likely that older Americans would benefit most of all.

A related aspect of this problem is the shortage of medical personnel. There are not enough physicians, nurses, dentists, medical social workers, physical therapists, psychologists, nutritionists, paraprofessionals, and other medical specialists to meet our nation's health care needs. Rural areas in particular suffer the effects of this shortage.

Transportation. An elderly man in Maine was recently discovered spending $25 a week in taxi fare—about half his income—to travel to a hospital for radiation treatments. Because his transportation costs were so high, the man was not eating well and was not fighting his illness as well as he could. This case illustrates once again the interrelatedness of older people's needs. It shows how a "non-medical" problem can frustrate the best efforts of a medical system which does not take these problems into account. Lack of transportation has been identified as one of the key problems of older Americans. Without a viable transportation system, the most effective and well-organized services provided in a central location are useless to older people who are isolated. Isolation is a major obstacle to better health care for the elderly.

Attitudes. Older people frequently have trouble obtaining proper medical care because many medical personnel are not highly motivated to serve them. One reason for this is that a doctor can seldom expect to bring about a dramatic and professionally satisfying "cure" in a chronically ill older person struggling with one or more serious medical complaints. This struggle ultimately ends in death for everyone, and medical personnel have a certain reluctance to face the final failure of their efforts. In addition, medical people, like all of us, are subject to the stereotyped attitudes regarding old age that pervade our culture. For example, consider this patronizing and negative description of older people in a standard psychiatric textbook widely used by students:

> A dislike of change, a reduction in ambition and activity, a tendency to become constricted and self-centered in interests, an increased difficulty in comprehension, an increase in time and effort in adapting to new circumstances, a lessened sympathy for new ideas and views and a tendency to reminiscence and repetition are scarcely signs of senile dementia, yet they pass imperceptibly into mental destitution and personality regression. Many elderly people have little capacity to express warm and spontaneous feelings toward others.

The writer continues:

> . . .The patient resents what he considers as interference by younger persons and may complain that he is being neglected. Some show a hostile but anxious and fearful dependence. Natural affections become blunted and may turn to hatred. A certain tendency to isolation occurs.

While this description applies to certain mentally ill old people, it is wildly inaccurate as a general statement. It illustrates the problem of "ageism" quite accurately.

Such stereotypic attitudes appear to affect physicians' ability to correctly diagnose and treat disease-related conditions among older people. In one study, 1500 general practitioners and internists were asked to classify a number of conditions occurring frequently among older people as either normal conditions of aging or conditions caused by disease. The results showed that doctors tend to dismiss many treatable disease-related conditions as normal occurrences of age. For example, between one-half and three-fourths of the doctors incorrectly classified senile cataracts, cerebral arteriosclerosis, retinal arteriosclerosis, senility, and enlarged prostate as normal conditions of age. The physicians were much more accurate in identifying normal conditions correctly. These errors appear to be ominous. If physicians tend to incorrectly identify disease-related conditions as normal, they are likely to leave untreated conditions that could be reversed. The findings of this study suggest that medical schools should pay much more attention to geriatric medicine.

Observations and Special Needs

Prevention. Since most chronic conditions and other medical problems first appear in middle age, an effective health program for older people obviously must begin before age 65. Such a program would include a lifelong practice of regular medical checkups, effective health education, and measures to facilitate early detection of disease. These preventive needs are extensive and largely unmet; prevention has only recently been drawing the attention and financing it deserves.

Common screening tests to detect symptoms of disease at an early stage are coming into wider use. Most serious and chronic illnesses—including glaucoma, heart disease, tuberculosis, diabetes, and cancer—can be treated successfully if detected in time. An important recent development is the wider use of "multiphasic" screening techniques which can detect several conditions in one procedure. However, screening programs often lack a follow-up and referral component to make sure that older people and others actually obtain necessary medical care. Another barrier is the fact that middle-aged and older people—those who would benefit most from health screening programs—are the people who are least likely to have developed the habit of regular medical checkups.

Another preventive measure is a comprehensive program of health education to instill enlightened health attitudes and habits in the general population. One example is the growing awareness that prevalence of heart disease—the leading killer—is closely associated with high levels of blood cholesterol. Through health education, people can learn to reduce these cholesterol levels by modifying their diets. Health education programs are particularly important for the elderly. Older people tend to ignore the onset of illness, often attributing ominous symptoms to the generalized problem of "getting old." As result, older people often needlessly succumb to infectious diseases. For example, tetanus is still a leading killer of people over 40, because older people frequently do not bother to maintain the immunizations that could prevent this disease. In addition, millions of Americans ignore the importance of exercise and physical activity to continued good health.

The task of health education appears to be formidable. A 1972 Department of Health, Education, and Welfare study documented widespread misinformation about health in the United States. The study suggested that a trial-and-error approach to personal health problems is the major cause of questionable health practices. Among the study's findings:

—some 12 percent of the adults interviewed reported they had arthritis or rheumatism, asthma, allergies, hemorrhoids, heart trouble, high blood pressure, or diabetes, even though these conditions had never been diagnosed by a physician. This group represents 16 million adults.

—some 12 percent also said they would self-medicate—without seeing a doctor—for more than two weeks if they suffered from sore throats, coughs, sleeplessness, or upset stomach.

—nearly half the adult population would doubt medical opinion that a hypothetical "cancer cure" was worthless. The study also found that most Americans attribute beneficial qualities to extra vitamins and nutritional supplements, despite the lack of medical evidence to support these claims.

Income. Poor older people have many more health problems than those of higher economic status. While about 12 percent of the older population in 1973 received public assistance, more than 50 percent of institutionalized older people received Medicaid or some other form of welfare. Minority groups and the single elderly—the poorest of the older population—are also the sickest. Older single people are more frequently malnourished and lack the emotional support which is vital for recovery from disease. Blacks and other minority groups have higher death rates than whites, as well as much higher rates of such diseases as cancer and diabetes. These problems are associated with lower income and with such environmental factors as the inadequate housing, poor safety, and poor sanitation which go with low income.

Stress. Severely ill and disabled older people are more likely than others to have undergone severe stress just prior to their illness or injury. Even older people already ill or disabled are more seriously afflicted by stress than others. In addition, older persons are frequently called upon to withstand a succession of crisis situations in their lives.

Retirement. Contrary to popular stereotype, retirement does not bring about illness, decline, and death. Some studies even indicate that older people's health *improves* on retirement.

II
MENTAL HEALTH

Efforts to determine older people's needs for mental health care mix guesswork with science. Every survey uses somewhat different diagnostic criteria of "mental illness." This merely reflects widespread uncertainty among psychiatrists and others about the definition of "normal" behavior, and about the real meaning of such terms as "psychotic," "neurotic," and "disturbed."

Slightly less than 1 percent of all persons aged 65 and over are patients in public and private mental institutions. This group is about equally divided between two sub-groups: those hospitalized for senile brain disease and other disorders arising in old age, and long-term psychotics who have grown old in the hospital. Another four percent of all old people live in nursing homes, homes for the aged, and other institutions. Authorities estimate that perhaps half of these institutionalized elderly suffer from significant psychiatric disturbance. Thus, at most, three percent of all older people live in institutions as a result of mental illness, or suffer mental illness as a by-product of their institutionalization. Most of those affected are aged 75 and over.

However, surveys among non-institutionalized elderly reveal a high level of mental disorder. One study indicated that the rate of psychosis among old people is 10 times the rate of those between age 15 and 34. A composite picture of several psychiatric surveys indicates the following: perhaps 5 percent of old people living in the community are either psychotic or have severe mental disturbances; another 15 percent are neurotic with crippling personality disorders; between 10 and 15 percent have mild or moderate degrees of psychiatric impairment. These surveys are all cross-sectional: they do not indicate to what extent, if any, mental disturbances increase in frequency with age. Neither do they distinguish between organically-based disorders and those which originate in the older person's personality structure or living situation.

A respectable body of psychiatric opinion holds that no individual who manages to function in the community can be considered mentally ill. This view does not deny that individuals suffer from emotional disturbances, or that their disturbances cause others to suffer as well. Those who take this approach simply say that "mentally ill" people have social and legal problems, not medical ones. Thus, while there are good reasons to doubt the precision of surveys of mental health care needs among old people living in the community, they do at least suggest an important area of need, the nature of which we might not fully understand.

Available Services.

Mental health services for older people are meager. The elderly either receive no psychiatric attention at all, or they are committed for long periods of time, often for life, to institutions which usually offer little more than custodial care. While old people comprise 30 percent of all public mental hospital patients and 11 percent of patients in private institutions, they account for only 2 percent of the patients in psychiatric outpatient clinics. Private psychiatrists often do not regard old people as attractive patients, and frequently lack training in the therapeutic techniques which are especially suited to therapy with older people. Medicare pays for only a small fraction of psychiatrists' fees, and most older people are unable to afford the cost of extended private psychotherapy.

The most promising approach to better mental health treatment for older people seems to be flexible, community-oriented, preventive services offered through local community mental health centers. While it is not certain that psychiatric disorders can be "prevented" at any age, the social measures which have historically been most effective in raising the level of health have been preventive programs aimed at entire communities rather than individual patients. The concept of "community psychiatry" in this country follows in this tradition. It is based on the notion that institutionalization—the traditional way to deal with disturbed persons—usually creates more problems for the patient than it can possibly solve. A flexible array of treatment interventions provided within the community avoids the special problems of institutional care. They are also more likely to build on whatever resources the disturbed individual may have. These measures include outpatient services in private practice or clinics, day hospitals for patients who need more extensive daily support, walk-in clinics and other crisis intervention, and brief hospitalization when necessary, usually in a psychiatric ward of a general hospital. Those community mental health centers which already exist serve a very small proportion of older people. Like many agencies serving the general population, community mental health centers tend to neglect older people and will serve them adequately only when pressured to do so.

Many mental health professionals feel the situation would improve if community mental health centers designated a staff person to coordinate and improve services for the elderly. This has already happened at the state level. More than 40 state mental health directors have now designated a staff member to be responsible for services to the aging. The National Association of Mental Health Directors has also created a special section on aging.

Comprehensive psychiatric services offered through community mental health centers would have special benefit for the elderly, for many old people are beset by multiple problems—medical, psychiatric, and social. These problems are interrelated, but the existing medical system treats them separately. The troubled old person frequently has the choice of entering an acute care hospital, where psychiatric help is usually unavailable, or a mental hospital—where his medical needs are likely to be ignored. One British study found that an unusually high death rate results when old people are admitted to the wrong type of facility.

Barriers to Mental Health Care

Myths. Popular myths and stereotypes about older people constitute a formidable obstacle to understanding their mental health care needs. Therapists do not want to treat old people because they are thought to be rigid, unresponsive to therapy, and inflexible. Simple bias is often involved. Mental health professionals often simply prefer to work with addicts, runaways, and other young people. These areas of specialization are also more generously funded by public and private sources than are counseling and therapy with old people. In reality, no evidence suggests that the elderly are any less responsive to therapy than any other age group. Those few specialists in geriatric counseling maintain that old people are amply responsive to sensitive therapy provided in reasonably promising circumstances.

A myth related to the rigidity stereotype is the common belief that "senility" is inevitable and that a mentally disoriented older person is on an irreversible downhill course. As we have seen, organic brain disease is a very specific condition caused by the physical deterioration of the brain cells or by the hardening of the brain arteries. It affects a relatively small proportion of older people. What's more, many of the behavioral difficulties in senile people can be relieved by timely and tactful medical and psychological intervention.

These myths have a terribly destructive effect. They instill a fatalistic attitude in everyone who could help the disturbed older person. Family members speak sadly about how the old person is "failing," and try to cope with the situation as best they can. Psychiatrists do not think the older person can be helped. Consequently, the mental health care system which psychiatrists dominate offers little help. Thus, the older person with a serious psychological problem is not likely to receive any help unless his condition becomes so bad that he is institutionalized.

Attitudes of the Elderly. On the other hand, older people are less likely than the young to regard psychiatry as a legitimate medical specialty which can provide help. In general, Americans recognize medical problems much more readily than psychological ones. Older people, raised in an age when emotional problems were customarily regarded as shameful, are less likely than anyone else to seek out a therapist for help. This attitude is not restricted to psychiatric treatment. Several studies have found that old people are more reluctant than others to seek out *any* kind of medical care. Apparently they regard physical and mental problems as a normal part of "getting old."

Finances. Our ambivalence about mental illness is reflected in the meager coverage of medical and psychiatric treatment through Medicare and Medicaid. The coverage provisions of these programs stress the active treatment of the acutely ill. Yet they limit modern psychiatric treatment of the elderly by excluding coverage of day care programs, outpatient and home visit programs, protective care, and other measures of value to the mentally ill elderly.

The hospital insurance section of Medicare covers inpatient services in mental hospitals, but places a strict limit on the number of days that the program will cover during an individual's lifetime. This provision was designed to encourage active rather than custodial care. However, no such limit is applied to the length of hospital stay for other illnesses. Medicare also covers psychiatric outpatient service, but will only reimburse $250 of the patient's annual expenses. This limitation appears to be particularly ill-advised, since prompt, relatively inexpensive outpatient care can in some cases prevent expensive hospitalization later.

Medicaid pays for much of the cost of institutionalization for poor older people, but the Medicaid program is in trouble in most states and is undergoing cutbacks. Medicaid has had little impact on the quality of the generally poor custodial care older people receive in state mental institutions and nursing homes. The program is also in part responsible for the heavy shift of state hospital patients into nursing homes. By transferring mental hospital patients into nursing homes, state authorities can shift the burden of expense from the states to the federal government.

Transportation. Lack of mobility is a serious barrier to use of mental health services by many older people. It particularly retards the use of the outpatient and day-care services offered in community mental health centers. These are usually central facilities serving a farflung suburban or rural region.

Special Needs

Grief. A traumatic bereavement often triggers a physical or emotional breakdown in older people. Mourning is essentially a healthy psychological process: it allows the individual to reconcile himself to the death of a loved one, and then to proceed with necessary practical and emotional adjustments. However, the process of mourning is poorly understood. Many older people are unable to change their lives sufficiently, and they sink into a dangerous, permanent grief.

Alcoholism. Problem drinking is a surprisingly large mental health problem among the elderly, particularly among men. About half the old people admitted to mental institutions have drinking problems. Alcoholism is the second most common disease among older people admitted to state and county mental hospitals. Among these older alcoholics, half are long-term alcoholics who have grown old; half are people who have begun to use alcohol late in life to cope with the troubles and loneliness of old age. As in many service areas, the special problems of the old alcoholic are often neglected by agencies which help problem drinkers.

Disability and Sensory Loss. The manifold physical and psychological ailments of old age often have subtle but important effects on the old person's mental health. Sensory loss and lessened mobility can isolate the old person and leave him to dwell on his anxiety and suspicions. Hearing loss in particular can disrupt an old person's emotional equilibrium by fostering suspicions about what others are saying.

The poor. Many of those old people admitted to mental hospitals come from the geriatric ghettoes in the middle of central cities. Most of these old people are quite isolated, depressed, and poverty-stricken. These poor elderly, living in broken-down rooming houses and hotels, constitute a group much in need of extensive health and mental health services. Because of their isolation, they are difficult to find and hence many are cut off from services they need.

III

INSTITUTIONAL CARE

Some one million older people—about five percent of the total older population—live in nursing homes, mental hospitals, hospitals, old age and retirement homes, and other institutional settings. Some of these facilities provide excellent care; many are shockingly deficient. As a whole, the existing institutional arrangements for older people are inadequate. The deficiencies of these institutions are a source of constant worry to old people and their families. Improving the situtation is a major challenge to social service providers and advocates for the elderly.

Two overriding problems dominate the discussion of institutional care for older people. First, most institutions fail to provide the level of care they say they provide. Staff and administrators tend to be poorly trained; facilities are inadequate; state and federal regulations are enforced poorly. Second, few institutions can respond adequately to older people's complex and interrelated needs. Mentally ill people languish in nursing homes; physically ill old people live in mental hospitals. Few institutions attempt to meet older people's needs for social contact and meaningful activity. Existing methods of financing institutional care are inadequate and, in some cases, have created additional distortions and inequities in the system. Consequently, most older people greatly fear institutionalization; most families will institutionalize an aged relative only with extreme reluctance. Creation of "alternatives to institutional care" to keep older people at home is an explicit priority of the federal government, and of state and area agencies on aging created under the Older Americans Act.

Studies indicate that families seldom "dump" or "railroad" older people into institutions. In most cases, the family tries by itself to cope with an old relative's deteriorating physical or mental condition. The family will try various alternatives, such as a housekeeper or round-the-clock nursing care, until a crisis occurs which makes commitment to a nursing home or mental hospital a necessity. Often this crisis has little to do with the magnitude of the person's physical or mental condition, but rather involves the family's resources. Thus, an old person may be institutionalized, not because his condition requires it, but because no one else can cope with it. In particular, behavior disturbances, such as serious confusion, delusions and deep depression, are likely to cause an old person's institutionalization. Nevertheless, most families accept institutionalization only as a last resort and show tremendous tolerance for aged relatives' problems.

When a family, a social service worker, or a court decides that an older person should be institutionalized, the person's fate is often determined by factors other than his physical or mental condition. Criteria for admission to state and private psychiatric hospitals are usually vague and quite variable. Perhaps one-third of the aged residents of state mental hospitals have no serious mental impairment at all, but simply have no place else to go. Criteria for nursing homes are even vaguer. The situation has been complicated by state mental hospitals which have begun discharging large numbers of their older patients—including mentally disturbed people—to nursing homes. One study of nursing home patients in Massachusetts concluded that only 37 percent needed skilled nursing care, 26 percent needed minimally supervised "living" arrangements, 23 percent could get along at home with periodic home visits by nurses, and 14 percent needed no care or supervision at all.

In summary, an old person's placement in an institution often depends on factors other than his physical or mental condition. These factors include availability of community services, admission policies of institutions, professional attitudes, and availability of financial support. This contributes to the problem of "misplacement." This is particularly serious when a physically ill person is committed to a mental institution, or a mentally disturbed person is admitted to a nursing home or other primarily medical facility. In neither case is the old person likely to get even minimal care for his primary ailment. As always, the very old, the poorest, the single, and the widowed are most likely to be institutionalized and to be misplaced.

Planners for the 1971 White House Conference on Aging identified the two greatest deficiencies in institutional care as: 1) lack of facilities for the overall medical management of chronically ill older people; and 2) provision for the care of acutely ill confused patients who are usually confined to state mental hospitals. Chronically ill older people in institutions are most likely to be in nursing homes, many of which lack both an adequate level of basic care and programs to rehabilitate elderly patients. Flexible rehabilitative measures are especially needed, since chronic illness typically follows a variable course, with remissions and relapses, acute crises, mild or severe disability, and frequent periods when the sick person can do other things than merely be a patient. For acutely ill old people with organic brain disease, a psychiatric ward of a general hospital is the preferred treatment facility. Yet such people are usually committed to state mental hospitals where they receive less than adequate care for their acute condition. Most of the old people on hospital psychiatric wards are diagnosed as either severely depressed or paranoid.

Types of Institutions

Hospitals. In 1968, 120,000 older people were patients in state and county mental hospitals, with another 15,000 in private mental hospitals and 3,000 in Veterans Administration hospitals. About two-thirds of these patients were hospitalized after age 65 with diagnoses of organic brain disease. The rest are long-term patients who have grown old in the hospital. An unknown but sizeable number of older people are also long-term patients in state, county, and municipal medical care facilities. They suffer from paralysis and other chronic conditions, but many are also mentally impaired.

Mental hospitals have drawn heavy criticism for their treatment of old people's physical and mental illnesses. They are plagued by the problem of misplacement; most contain many old people who are not especially ill but who have no place else to go. Frequently, these institutions offer only custodial care: old patients are given strong dosages of drugs to inhibit erratic behavior and left to vegetate on back wards with only television to occupy their time. In recent years, states have been moving older mental patients out of hospitals and into nursing homes, largely to take advantage of federal Medicaid payments for nursing home care. Similarly, many counties and municipalities are closing their medical care facilities and moving disabled and chronically ill patients to nursing homes.

While much criticism of mental hospitals is amply justified, some mental health planners argue that nursing homes are no more appropriate for mentally ill older people than are the back wards of isolated mental institutions. At least, hospitals usually have better facilities, grounds, and more qualified professional staff than nursing homes. The problem is the inadequacy of the treatment available in either type of facility. Comments Robert Butler, a geriatric psychiatrist: "the mental hospital symbolizes being 'old and crazy' whereas the nursing home means that one is 'old, incapacitated, and about to die.' Neither represents a positive approach to mental health care."

Some mental health professionals have demonstrated the feasibility of turning mental hospitals into effective treatment facilities. The work of Dorothy Coons at Ypsilanti State Hospital in Michigan and Lionel Cosin in Oxford, England shows how a creative approach to treatment can turn a static hospital ward into a truly therapeutic environment. These techniques can teach many older patients enough skills to enable them to return to the community.

Nursing Homes. Most institutionalized elderly live in nursing homes or other long-term nursing care facilities. The average age of nursing home residents is 78. Two-thirds are women and 96 percent are white. Between 85 and 90 percent of old people entering nursing homes die in them; one-third die within the first year and another third die during the second and third years. A number of nursing homes supply excellent care, but more are deficient, some seriously so.

Three major themes run through the many criticisms of nursing homes. First, the level of care is generally low and at best only keeps the patient alive. Second, the nursing home environment is dehumanizing and frequently downright dangerous. Third, nursing home personnel—from administrators to aides—are poorly trained. Each of these criticisms is periodically illuminated by major scandals. Patients have died in bed and been discovered several days later. Homes have burned down, patients have been poisoned by spoiled food, home administrators have been found to be embezzlers, and drug addicts have been hired as nursing aides.

These situations exist largely because the massive dose of public money injected into the nursing home industry has not been followed by effective governmental regulation. Nursing homes are a big, growing commercial industry—90 percent of all homes are profit-making—yet government pays most nursing home costs through Medicare, Medcaid, and state assistance programs. These programs have, in fact, largely created the industry. Since Medicare and Medicaid were enacted, making nursing home care widely available to old people for the first time, the number of homes has doubled and the number of beds tripled.

Regulation of nursing homes has been a continuing problem and inspection sanctions have rarely been pursued vigorously. Substandard facilities are allowed to remain open on the theory that patients in them would have no place to go if they were closed.

Despite the availability of public money, only the very wealthy can afford good nursing home care. Good care is very expensive and is available in a rather small number of homes. Medicare will pay for a limited stay in a nursing home only if the patient has been hospitalized first. Even then, the older person must pay part of the cost, and he can stay in the home under Medicare for only 100 days. After that, the patient must either be rehospitalized or assume the full cost of his care. Medicaid will pay the cost of nursing care if the older person is poor. If the individual in need of nursing home care has moderate resources, he must first exhaust them, and then apply for Medicaid after he has become poor.

Homes for the Aging. Homes for the aging are residential facilities for old people that ordinarily provide some help with personal care, grooming, getting around, and other necessities. Many have nursing facilities attached for residents who become seriously ill. However, these homes will not accept older people who are already ill, and most serve a relatively restricted clientele. Most are operated by religious and fraternal groups, and they tend to be expensive.

Nevertheless, the home for the aging apears to be a promising alternative for those many older people who cannot or will not live independently. A few homes for the aging have evolved into campuses where many types of services and living situations are offered to meet progressively greater levels of need.

Special Concerns in Institutional Care

Relocation. Abrupt, involuntary relocation of institutionalized elderly is frequently lethal. A recent study at The University of Michigan found that half of a group of old people who were moved from one institution to another died within six months of the move. However, the same study indicated that much of the impact of relocation could be blunted by a relatively simple pre-move preparation program. The problem of relocation is becoming more serious as larger numbers of old patients are shifted from state hospitals to nursing homes and from home to home.

Physical Environment. Gerontologists and therapists are beginning to exploit the rich therapeutic possibilities involved in changing the drab environments of hospitals and nursing homes. The oppressive, maximum-security atmosphere of most mental hospitals not only obstructs effective therapy, but has been found to create its own "institutional neurosis" in troubled mental patients. The typical nursing home is a sterile place, more like a motel than a home-like environment where residents can function in normal social roles as much as possible.

Right to Treatment. A recent development with significant implications for institutional care of the elderly is found in legal attempts to define a constitutional "right to treatment." The first breakthrough in right to treatment came in 1966 when a federal judge in Washington, D.C. ordered a mental hospital patient freed because his confinement constituted punishment and not treatment. The individual in question had been convicted in court on a misdemeanor—an offense carrying a maximum sentence of one year—but had been languishing in a mental hospital for four years. Subsequent cases determined that patients committed to a hospital as a result of criminal charges or convictions had a right to be treated and eventually released. In 1973, the Supreme Court upheld these rulings. The Court said that "due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed."

A 1971 case extended the right to treatment to *all* mentally ill and mentally retarded persons, whether they were committed through criminal or civil proceedings. The court, in a decision with potentially great impact on institutionalized older people, ruled that mental patients had a constitutional right to treatment. The court order, directed to the mental hospitals in Alabama, focused on the need to make a wide range of treatment alternatives available. It specified "a humane physical and psychological environment, adequate staff, and individual treatment plans." The case was appealed, was upheld by the Fifth Circuit Court of Appeals in New Orleans, and is now awaiting final decision by the U.S. Supreme Court.

This ruling, if upheld, has immeasurable potential consequences for older people with mental and even physical ailments. In all likelihood, the warehousing of mental patients with drugs—with only television and meals to break the monotony—would have to stop. Psychiatrists and mental health workers would have to make a sincere effort to treat patients and release them.

Age Segregation. An unresolved question is whether geriatric patients should be placed in units by themselves or in units with patients of other ages. At least one study indicates that mixing patients benefits everyone, but others suggest that old patients are neglected in age-integrated facilities.

IV

NUTRITION

The 21 million American elderly probably constitute the most malnourished segment of our population. This is so because all the other problems of old people—especially poverty, physical and mental illness, isolation, and immobility—make it less likely that they will eat well. About a quarter of all older people are poor; they have trouble obtaining the necessities of life. Even older people who are not poor live on relatively fixed incomes. They are badly hurt by the staggering rate of food price inflation, which reached an annual rate of 30 percent in the mid 1970s. In addition, physical disability and lack of transportation limit many older people's shopping trips to the high-priced neighborhood "Mom and Pop" grocery stores. They cannot reach the discount chain food stores in suburban shopping centers. Finally, many isolated old people simply lose interest in cooking and eating. Mealtimes are social events in our culture, and many old people who live alone cannot bear the thought of sitting down to a solitary meal.

Old age also brings special dietary needs. Diseases and conditions associated with aging—including diabetes, gastric acidity, biliary tract and pancreatic diseases, and cancer—affect nutrition and frequently require special diets. However, these special diets often cause problems of their own. Older persons frequently develop several conditions over the years, and modified diets are prescribed for each one. Yet successive diets restricting more and more foods may cause the older person to become malnourished or unable and unwilling to follow diets prescribed.

While most nutritionists would be happy if older people ate as well as everyone else, others aim higher. Some recent biological research indicates that cellular aging is associated with less efficient processing of nutrients. This suggests that old people should perhaps eat a diet higher in protein and vitamins than the average. Also, the linkage between diet and heart disease is becoming more closely established, and many nutritionists think most Americans eat a diet far too rich in fats, carbohydrates, sugar and "junk" foods. If so, old people can become malnourished on a "normal" American diet.

CHAPTER 12

TRANSPORTATION, HOUSING, EMPLOYMENT

This chapter is a discussion of certain community-wide systems and programs: principally, housing, transportation, and employment. All of them directly affect the older person's ability to function as a normal member of the community in which he lives. All must be addressed by effective planning on the community level, usually in concert with state and federal agencies.

I
TRANSPORTATION

Anyone concerned about delivering social services to older people, helping the elderly enjoy more fulfilling lives, or simply seeing an older friend or relative more frequently must soon come to grips with the severe old age transportation problem. As William R. Hutton of the National Council of Senior Citizens commented to a Congressional committee: "Being without transportation is like having a modern kitchen with all the latest appliances and no electricity." Hutton went on to link poor transportation to most of the pressing problems facing the older population, including limited access to social services and recreational opportunities, isolation, loneliness, hunger, poor health care, and inadequate income.

The old age transportation problem stems from four main factors: (1) many old people cannot afford the cost of transportation; (2) many live in areas which are poorly served by public transit; (3) many older people have difficulty using the public transportation system; (4) the American transportation system is based on use of the private auto. These factors are interrelated. Because they are poor, many old people live in areas which are not well served by public transportation. Because they do not have access to transit systems, they cannot go to work to supplement their incomes. And so on.

Major Issues

A primary cause of the transportation problem is low income. One-fourth of all older people live in poverty. Most live on incomes which are severely squeezed by inflationary pressures. They must spend most of this income on food, housing, and medical care, leaving little money for "luxuries" such as a private car or even public transportation. Most older people do not drive. Those who do must cope with ever-higher gasoline prices, insurance, and auto maintenance costs. Those who do not drive must walk, rely on friends, or pay rising public transit fares. Thus, by virtue of their low incomes, old people have trouble obtaining any kind of transportation.

Even if older people have enough money to use public transit, services are usually only minimally available in the areas where they live. The rural and suburban elderly are often totally without public transportation; the private auto rules supreme outside the central cities. Within cities, the public transit system is geared to the rush-hour needs of commuters, not to old residents.

The root of the problem is the dominance of the private automobile. The car influences land use and zoning patterns, and highway construction absorbs all but a small fraction of public transportation funds. Even light signals, traffic markings, street signs, and other pedestrian helps are geared toward the smooth flow of automobile traffic—one reason why old people constitute a disproportionate number of pedestrian fatalities. The private auto, with the economic and social changes it has brought about, has destroyed public transit systems in many cities. When people can afford cars, they stop riding buses, reducing the transit system's income as its operating expenses rise. Fares go up to cover expenses, further discouraging additional riders. Routes are curtailed, quality of service declines, and equipment deteriorates. The poor, the very young, and the old cannot support a transit system caught in this circular dilemma.

Furthermore, many older people cannot overcome physical and psychological barriers to the use of public transit systems. To ride buses and subways requires a high degree of speed, mental agility, and quick reactions. Printed schedules are often largely incomprehensible. It is frequently impossible to obtain information over the telephone from the local bus company. According to some studies, the most serious obstacle to better transportation for the elderly is a psychological reluctance. Old people are simply unwilling to face the uncertainties, terrors, and dangers of a bus ride.

These dangers are real, because much of the public transportation in the United States seems to be designed for the strongest, hardiest, and most agile riders. High bus steps, hard-to-open exit doors, poorly-placed handrails, and open air bus stops without benches constitute formidable physical barriers for older people who must rely heavily on public transportation. Design engineers and public transportation authorities, working together in a creative partnership, can do much to make systems more accessible to older riders.

A Worsening Problem?

Policy-makers at all levels of government have been aware of the old age transportation problem for some time, at least since the 1971 White House Conference on Aging recognized it as a major issue in need of solution.

Old people are among the most numerous of the "transportation disadvantaged," one of the newer bureaucratic terms describing a group of Americans whose immobility constitutes a major social problem. Authorities concede that they can do little in behalf of old people unless they do something to relieve their transportation problems as well.

Nevertheless, older people's transportation difficulties seem to be getting worse. The energy crisis, and the subsequent steep increase in gasoline prices, have made it still more difficult for that minority of older people who have driver's licenses to operate automobiles. The process of decline in public transportation systems in both large and small communities is speeding up. The outward thrust of suburban development intensifies everyone's reliance on the private automobile.

Federal action to improve transportation systems for the elderly has unfolded slowly. The Urban Mass Transportation Administration (UMTA) has spent some $2.5 million for research and demonstration projects for the "transit-deprived" groups; less than half this sum has been devoted to projects specifically designed to serve the elderly and the handicapped. However, UMTA has declined to spend an additional $44 million in research-demonstration-capital assistance funds which Congress appropriated. Another source of federal aid is a provision in the 1974 Congressional Amendments to the Federal Aid Highway Act which earmarks two percent of the total $6.1 billion appropriation to finance programs for the elderly and handicapped.

More federal aid is to be welcomed, for state and local authorities have shown a willingness to experiment with new methods of serving the transportation needs of the elderly. The most promising of these experiments go beyond the familiar "reduced fare for seniors." Reduced fares, while helpful, do not deal with inadequacies of the existing transit systems, nor do they help older people who live in areas with no transportation at all. Rather, these problems are relieved by transportation systems employing a "demand-responsive" concept, a term for a vehicle that comes to your door when you want it, and takes you where you want to go.

"Dial-A-Ride" and other "demand-responsive" transit systems for older people have been successful in both urban and rural areas. In Rhode Island, the non-profit Senior Citizens Transportation Corp. provides 10,000 rides annually with 27 minibuses operating on a statewide basis. A similar service operates in mostly-rural Missouri, the state which ranks sixth in the nation in the percentage of residents aged 65 and over. Both the Rhode Island and Missouri systems rely on federal subsidies for capital expenditures and operating expenses.

Other experimental transportation subsystems are adapted to the special needs of particular groups of the elderly. These include transportation cooperatives operated by retirement communities, senior centers, or private groups; subsidized use of taxis and jitneys; off-hours use of school buses; use of government surplus vehicles; and station wagons and small buses operated by social service agencies for their elderly clients.

While these special-purpose systems serve evident needs, they have their disadvantages as well. Transportation experts note that they are relatively inefficient, with a high cost per unit of service. Some are short-lived. Others are inadequate efforts to solve transportation problems which require a high degree of coordinated planning, broadly-based funding, and central control.

Substantial efforts to solve the old age transportation problem must largely await the formulation of a coordinated federal-state-local transportation policy. In testimony before the Senate Special Committee on Aging, William G. Bell and William T. Olsen, transportation experts from Florida State University, suggested these measures:

—recognition of urban mass transit as a social service delivery system, rather than as a private enterprise system.

—greater flexibility in federal funding of operating costs.

—integration of older people's transportation needs with the needs of other disadvantaged groups.

—enforcement of federal law entitling the elderly and handicapped to full rights to use urban mass transit systems.

—centralization of transportation planning for the elderly in state agencies.

II
HOUSING

The housing problems of the elderly fall into two basic categories. First, many old people have serious difficulties living in the homes they have occupied for many years. Much of their housing is substandard, and many old residents have neither the money nor the energy to improve the condition of their homes. Even middle-class old people living in their own homes must cope with high property taxes and spiralling maintenance and repair costs as best they can. Second, the supply of housing designed for older people is severely limited. In particular, there is very little "congregate" or group housing that would provide frail old people with an alternative to completely independent living or institutional placement in a nursing home or other long-term care facility.

Thus, very few older people will be entirely free from at least some housing difficulties in later life. They are caught between a desire to stay put and the need to adjust to changing physical and social circumstances. On the other hand, most old people desire to live independently, and have a strong bias against moving. Studies indicate that the factors reflecting a poor living situation—high living costs, loneliness, distance from relatives and friends—are unlikely to motivate old people to move unless the situation becomes very serious. Neither is the availability of good housing elsewhere likely to cause older people to look more favorably on relocation, even though a move may be inevitable.

On the other hand, most living arrangements become less adequate with advancing age. House furnishings are incompatible with physical limitations. High shelves, heavy doors, bathtubs and showers which are difficult to enter, inadequate lighting—all these become troublesome and often quite hazardous. Children leave and spouses die, leaving the surviving old person with more house and more responsibility than he needs. The neighborhood changes, shattering networks of friends and activities. The conflict between a desire to remain independent and the changing housing needs of old age places older people under a high degree of tension.

Substandard Housing

Older people tend to live in older, less valuable, and more dilapidated homes. An estimated 30 percent of all older Americans—more than six million people—live in substandard housing. Among poor older people, the situation is significantly worse. Forty percent live in housing with major defects. Those dwellings lack running water (15 percent); inside toilets (30 percent); hot water (40 percent); and/or central heating (50 percent). Substandard housing is commonest in rural areas and in the South. The 11 Southern states have 68 percent of all the substandard housing in America.

Homeowners

Although 70 percent of all older people own and live in their own homes, homeownership is no guarantee against serious housing problems. On the contrary, homeowners struggle with their own set of difficulties. Nationally, property taxes increased by nearly 30 percent between 1963 and 1969; costs of maintenance and repair jumped by one-third in the same period. These figures are higher for the high-cost, high-inflation metropolitan areas where most Americans want to live. Because of their low incomes, old homeowners are less able to make the essential repairs that older homes require. Not only do they have less money to spend, but old homeowners are physically less able to do maintenance work themselves. The old homeowner has less money and less strength, but probably lives in a home that requires more maintenance work.

Property tax relief ranks near the top in surveys of older people's expressed housing worries. The property tax is an antiquated, regressive form of taxation rooted in an old rural system where a man's land holdings were a fair measure of his wealth. Today, property values are a better indication of an individual's mortgaged indebtedness. Nevertheless, property taxes remain the major source of revenue for municipal government and school boards. People with low or fixed incomes bear a disproportionate share of the property tax burden. Nationally, older homeowners pay eight percent of their income in property taxes—twice the percentage working homeowners pay. Many older people cannot bear this burden, and are forced to seek other housing—usually less adequate housing—on the rental market. Older homeowners also have the grim alternative of cutting back elsewhere in their budget to pay the levy. Many states and communities offer a property tax rebate to their older residents. But since this means that other homeowners must bear a heavier load, many authorities argue that abolition of the property tax and creation of a different system is the fairest step.

In the past, the welfare system has imposed a cruel burden on poor elderly, 34 percent of whom own their own homes. In most states, these individuals could not qualify for Old Age Assistance if the value of their homes was above a certain limit. This provision made little sense, for equity in a home is a theoretical rather than a liquid asset for most people, old or young. Equity in a home cannot readily be converted into cash for food. Many states also imposed a lien against property or a claim against the individual's estate before he could receive Old Age Assistance. These provisions have discouraged poor elderly homeowners from applying for necessary help.

These problems have been only partially alleviated under the federal Supplemental Security Income (SSI) program which replaced the state Old Age Assistance programs. An individual can own a home with a fair market value of up to $25,000 and still be eligible for SSI. However, this regulation does not take into account regional variations in home market values, nor does it consider the homeowner's equity. These restrictions prohibit many of the more than one million poor elderly homeowners from receiving SSI payments.

The Housing Supply

Like most national problems, our housing shortage hits older people particularly hard. They have greater and more specialized housing needs than the young, but they have less money to compete for their housing on the open market. Except for a few private and expensive retirement communities, the creation of housing specially designed for the elderly is entirely a government-subsidized enterprise.

During the latter part of the 1960's, federal outlays for low-cost housing more than doubled. About 370,000 units of housing were produced through four major programs: direct sponsorship of public housing, direct loans, mortgage insurance, and farm loans. Not all of these units were built for old people, and they by no means ended the low-income housing shortage. Nevertheless, they represented solid accomplishment.

Early in 1973, however, the Nixon Administration undertook a series of steps which threw federal housing policies into a state of extreme uncertainty. In January, the Department of Housing and Urban Development imposed a moratorium on all major housing programs, including those of special importance to the elderly. Later, a HUD study termed past programs as failures, and promised to replace them with a system of direct cash grants to low-income people who could then "shop" for suitable housing on the private market. The President then backed away from even this program of housing allowances, saying it would have to undergo extensive study and experimentation. Finally, the administration agreed to subsidize new housing through a program which will pay developers the difference between the rent they charge and the rent low-income people can pay.

These steps, interim measures only, have drawn criticism from advocates of the elderly. The now-frozen public housing programs constructed many thousands of low-cost housing units specially designed to accommodate the physical limitations of older people. This is much less likely to happen under Section 23 Leased Housing Program—the rent subsidy plan—or under housing allowances if they are ever implemented. Behind both plans is a "marketplace" philosophy which will put older people in competition with younger individuals seeking low-cost housing.

Under Section 23, new units must be built through local housing authorities. Once the local HUD area office certifies the need for a certain number of units, the housing authority asks for bids. Non-profit housing sponsors, who have built most of the existing housing designed for older people, feel that this procedure puts them at a disadvantage. Religious organizations, labor unions, and service clubs are convinced that they will be continually outbid by private developers who have the necessary staff and seed money to put an application together. It appears that the Section 23 program will significantly enhance the role of private developers and owners of housing leased to low-income families.

The proposed housing allowance program fits neatly with Section 23. If implemented, this program will give cash housing subsidies to low-income people. Presumably, these individuals can then compete equally with middle-income renters for available privately-owned housing. However, this plan is unlikely to motivate private landlords and developers to remodel housing to suit the needs of low-income elderly. It would also appear to have limited value in areas of the country where little vacant housing exists. In these areas, especially the Northeastern states, allowances will likely spark an inflation in rents, and provide an added windfall to slumlords.

On balance, it is impossible to assess the impact of such uncertain proposals. HUD authorities indicate that about 25 percent of Section 23 Leased Housing would be reserved for the elderly and handicapped. They also promise that low-income elderly would receive their fair share of housing allowances. However, the apparent limitations of these programs make them problematical.

Somewhat more certain is the need for a vastly increased housing supply for older Americans. Allan F. Thornton, a HUD analyst, recently estimated that between 400,000 and 500,000 housing units could be sold to older people each year if they were designed to accommodate their special needs. This is the estimate for private, unsubsidized housing. With subsidies, Thornton suggests that the estimate could double to 800,000 units or more. Thornton laid down these criteria for housing to accommodate the needs of older people: physical security (from both violence and accident), health care (availability of nursing and medical services), daily needs (food, rest, and recreation), and convenient transfer of home furnishings and convenient disposition of equity in owned homes. Thornton's estimate of the housing needs of old people is among the first to be based on reliable analysis. It suggests that the 1971 White House Conference on Aging's plea for 120,000 new housing units for the elderly each year is exceedingly conservative.

III
EMPLOYMENT

Perhaps the most serious age-related employment problem does not affect the old but the middle-aged—those between ages 40 and 64. The middle-aged worker is more likely than his younger counterpart to be laid off, to be unemployed for a longer time, and to eventually drop out of the labor force long before he is eligible for Social Security benefits. For many older Americans, financial problems are much more serious because they have been working sporadically or not at all for a number of years before they reach age 65. Some analysts of the problem estimate that the actual unemployment rate among workers 45 and over is more than 15 percent. In 1973, the Senate Special Committee on Aging estimated that 867,000 workers aged 45 and over were out of work—a jump of 45 percent in four years.

Older workers are victims of technological change, product innovation, and the occupational shifts in employment which have occurred in the postwar era. Those who are aged between 40 and 65 today went to work in a "blue collar" economy, their job skills and attitudes shaped by the economic world of the 1930's. The shifts which have created today's "white collar" economy have worked to their disadvantage. Thus, older workers are concentrated in such industries as mining, railroads, textiles, skilled crafts, and heavy basic industry. These occupations are lower-paying and have grown less rapidly—or have actually declined—relative to the entire economy. Marketing innovations have displaced thousands of small, specialized commercial proprietors—many of them older people. The number of unskilled jobs has declined, and the demand for semi-skilled labor is increasing at only about half the rate as the demand for skilled labor.

Even older professionals suffer from the abrupt changes that have transformed such occupations as engineering and research and development. Studies show that engineers over 45 are likely to have moved into administrative and managerial jobs. Those who continue to function as engineers are competing with younger engineers with more up-to-date skills.

In short, middle-aged workers are vulnerable. Seniority protects union members when a single firm is undergoing a slack time. It helps very little when whole industries and thousands of workers are being displaced.

Once out of a job, older workers have a difficult time. They stay unemployed twice as long as younger people. Those who find work generally lose ground, finding employment in lower-pay, lower-status jobs such as light industry, routine clerical work, and personal care. Many leave the labor force entirely and cease to be counted in the official unemployment statistics. By the end of 1970, an estimated 8.3 million workers had withdrawn from the labor force, more than twice as many as 20 years ago. If this trend continues, one man in six aged 55-64 will be out of the labor force; ten years ago, the figure was one in eight. Their unemployment is often attributed to illness, but illness is often a euphemism for giving up. Even illness is exacerbated by frustrating failure to find work. These men have no pensions and usually very little savings, if any. Their only option is to apply for early Social Security benefits at age 62. These benefits are then reduced for the rest of their lives.

Manpower experts expect the problems of the older worker to worsen. Older workers suffer when economic life is characterized by mass displacement of entire work forces. The rapid pace of technological change and shifting market trends seem to assure that such displacement will be common in the American economy for many years. More than ever, employment will depend on the level of the worker's formal training, with employers valuing education more highly than experience.

Age Discrimination in Employment

Officially, age discrimination in employment is against the law in the United States. The 1967 Age Discrimination in Employment Act bars employers from denying job opportunities or dismissing employees 40 to 64 years old solely on the basis of age. The statute also prohibits age bias in job retention, compensation, promotions, and other conditions of employment.

Enforcement of the act has accelerated in recent years. The Department of Labor prosecuted only 10 cases of alleged age discrimination during the first three years of the act's existence. The total has since risen to more than 180. In fiscal 1973 alone, 2,900 businesses were found to be in violation of the statute, in cases affecting 15,000 workers. Most of these cases were settled out of court.

One 1974 case, the largest ever, ended with an agreement by the Standard Oil Company of California to pay $2 million to 160 employees in compensation for discriminatory practices. Two earlier court decisions, against Greyhound Bus Lines and Pan American Airways, upheld the statute's provisions and greatly expanded grounds for legal assault on age discrimination practices. Since the Department of Labor largely relies on conciliation and voluntary compliance for enforcement, these well-publicized cases should encourage other firms to change personnel policies which fall under suspicion.

Yet age discrimination in employment remains pervasive. It has turned out to be a notoriously subtle and complex set of practices which are difficult to define in legislation and to enforce through administrative procedures. One private consultant specializing in personnel policies told a seminar of the National Council on the Aging that age bias is a form of discrimination that enjoys widespread approval in American business. Frank P. Doyle, the consultant, asked, "How many times have you seen a manager praised and promoted because he headed an organization that was filled with young tigers; old lions just don't seem to boost you up the corporate ladder. How many annual reports . . . proudly state that the average age in the top management has come down from 58 to 46?" Doyle concluded that age discrimination laws were trying to change a durable popular value that young is better than old.

To put more teeth in the law, Congress is considering proposals to increase funding for enforcement. The Labor Department has only 69 positions specifically budgeted for ADEA. The 1,000 Labor compliance officers devote an estimated 10 percent of their time overseeing the Act. This amounts to 100 compliance officers overseeing the 685,000 business establishments covered under ADEA. It is also considering amendments which would extend the act to federal, state, and municipal employees, and to businesses with 20 or more employees. Currently, the Act covers only firms which employ 25 or more persons.

Training and Placement

A key to improving the employment situation of older workers lies in improving the scope and quality of the training and retraining programs available to them. All available data show that existing training programs assign a much lower priority to older workers than to young people and members of minority groups. While they make up 40 percent of the labor force, workers over 45 make up only 10 percent of those enrolled in job training programs. In recent years, state and federal regulations have forced the operators of these programs to admit more minority group members, young people, dropouts, and hard-core unemployed, often requiring special catch-up and compensatory courses to accommodate them. The same should be done for older workers.

Public and private job placement services show a similar distortion in their priorities. Until recently, most of these services have stressed the quantity rather than the quality of placement. Counselors concentrate on the younger, easy-to-place worker rather than on his older colleague. Older workers require much more time for the initial interview, follow-up advice, and at least twice as many referrals as younger workers. Employment agencies, incidentally, must comply with the Age Discrimnation in Employment Act. They cannot prefer younger applicants on the basis of age merely because an employer-client has instructed them to do so.

A serious problem manpower specialists encounter when counseling older workers is their reluctance to move and to change occupations. One study by the Ford Foundation showed that older workers were not willing to look for a job in a new occupation, were unwilling to adjust their previous wage rates downward, and were not particularly interested in retraining. These attitudes, understandable as they may seem, reduce older people's chances of finding work.

Some of the necessary changes may begin to happen through implementation of the Comprehensive Employment and Training Act of 1973. This law makes federal assistance available to states, cities, counties, and other sponsors for a variety of manpower and training programs, including several for older workers. The Act specifically mentions programs which provide recruitment, placement, and counseling for middle-aged workers affected by plant closings or permanent high rates of local unemployment. It also requires sponsors to give special consideration to workers unemployed for long periods of time. Older workers tend to remain unemployed twice as long as younger workers. The Act also supports programs to provide part-time work in community service projects to unemployed workers aged 55 and over.

Perhaps the situation of the older worker will improve when it is generally recognized that a problem exists. This may generate the necessary sensitivity on the part of employers, training specialists, and placement counselors that will lead to significant changes. Fuller utilization of middle-aged workers will benefit everyone, for our prosperity depends on the most efficient use of the labor force. Until then, older workers will continue to have trouble staying employed.

CHAPTER 13

THE LAW AND THE OLDER PERSON

Professional groups' growing awareness of the needs of older people has brought an intensified interest in the older person's relationship with the law. Police officials have found that older people are extremely vulnerable to crime. Judges are repeatedly faced with delicate decisions about older individuals' competence to manage their affairs. To serve their older clients, lawyers in private practice must master a growing body of complex law regarding wills and trusts, institutional care, pensions, and public assistance programs. Much of this new interest in the legal needs of older people can be traced to the mid-1960s when the Office of Economic Opportunity began providing legal services to the poor. Since millions of the poor are also old, a generation of poverty lawyers and government decision-makers have had to confront the legal problems of the elderly.

The poverty lawyers found that the law had great potential to help the elderly poor. Through court suits, they could compel providers of social services to initiate or improve services to old people. The lawyers found that they could often correct abuses of older people's rights by representing the elderly at administrative hearings, by threatening suit, or simply by writing letters to offending bureaucrats. The law started to become a new and promising way to correct abuses and solve older people's problems.

At the same time, advocates for the elderly began to use the law as a tool to accomplish major expansion of older people's rights and privileges. The seemingly limitless potential of such action was shown in 1972 in Massachusetts. On petition from a legal reform group, the state Department of Public Utilities agreed to entertain a proposal that would have granted a 50 percent rate reduction to every telephone subscriber in the state over age 62. The department later decided it lacked the statutory authority to grant the reduction, but suggested that advocates for the elderly seek legislative change granting such authority from state lawmakers. In other states and municipalities as well, legal action has encouraged older people to engage in political action.

However, the law can hurt older people as well as help them. Old people can be stripped of their civil rights through incompetency proceedings which frequently place their affairs in the hands of a guardian without traditional safeguards of due process. Old people who exhibit disturbing behavior and lack legal counsel can be swiftly committed to mental hospitals, again often without due process. Restrictive interpretation of legislation and departmental regulations can deny older people their entitlements from public programs such as Social Security and SSI. Another area of neglect and need is law enforcement. The elderly are vulnerable to consumer frauds and swindles, and most law enforcement agencies give no special attention to protection of old people, even though the elderly are victimized by criminals more frequently than any other group.

This chapter offers a summary of some of the major aspects of the legal system as it affects older people. It concludes with a discussion of the issues involved in providing more extensive and more effective legal services to older individuals.

It should be emphasized that structures to serve the legal needs of older people are only beginning to evolve, and that these legal needs are only dimly perceived by lawyers, social service providers, gerontologists, and older people themselves. Legal research efforts and law reform cases in a few widely scattered places suggest the beginnings of a specialization in the law of old age. Similarly, some legal services agencies, senior citizens groups, and national associations have just begun to experiment with organizational arrangements to serve the elderly. However, neither the law of old age nor structures to apply this law to the problems of older people have yet fallen into very clear patterns. We speak of them only as they begin to coalesce.

I

LEGAL NEEDS AND ABUSES OF THE SYSTEM

Crimes Against Older People

Law enforcement agencies and the criminal justice system have traditionally paid little special attention to crimes against the elderly. They have considered a crime against an older person as a crime against a person of any age. In criminal statutes, in crime reporting, in the courts, and in the operation of police departments, the law has largely been blind to age.

However, a close look at crime statistics and at the social situation of older people suggests that crimes against the elderly constitute a still-ignored national problem. An Oakland, California study found that women over age 65 were six times more likely to be robbed than others in the general population. More than half the female victims of street robberies were over age 55; more than a third were aged over 65. In four of the five largest cities in the country, persons over 50 suffered the highest rates of larceny and assault.

In fact, the extent of crimes against older people is unknown. Except for minors, the age of the victim is rarely included in crime reports. Also, a federal study indicates that perhaps the majority of crimes are never reported to the police. Victims of crime—young as well as old—often feel that nothing will be accomplished by reporting the incident to police, or that the incident was not important enough to deserve police attention.

Yet at least this much is known about crime against older people:

—older people are more likely to be victimized repeatedly—often by the same crime and the same offender;

—older people are concentrated in high-crime neighborhoods in close proximity to those most likely to victimize them;

—theft of monthly pension and Social Security checks is a persistent and growing problem for business and government;

—older people are particularly susceptible to frauds and confidence games.

Older people are popular victims for criminals simply because they are vulnerable in so many ways. They are more likely to live alone and more likely to suffer from chronic ailments and loss of hearing and sight. They tend to be frail, unable to defend themselves against an attacker. Many old people depend on walking and public transportation to get around, making themselves accessible to potential attackers.

Crime and fear of crime has a traumatic effect on older people's well-being, mobility, and independence. Fear of crime causes self-imposed "house arrest" among old people living in high-crime neighborhoods; many hardly ever venture out of doors. Since older people are poorer, any economic loss through crime is relatively greater. Perhaps the personal significance of crime transcends the purely legal question. Exploitation by landlords, salesmen, confidence men, and health quacks; robbery and violence by street criminals—all these inflict psychological as well as economic and physical injuries on older people. They surely contribute to the frustration and fear that too often characterizes old age in America.

A persuasive argument can be made for treating crimes against the elderly as a distinct category. Political leaders, rock music stars, women (especially with regard to rape), and bank employees all enjoy the benefits of a public policy which holds that the equal protection of the laws is best realized through special treatment of some groups. The 1971 White House Conference on Aging called for just such a step, and made two specific recommendations to implement it. The first is to make more effective police protection of the elderly a top priority. The Conference asked that a portion of the federal funds for improving local crime prevention be earmarked for protection of the elderly. The Conference's second recommendation was to develop and implement standards for physical and environmental security in all housing projects serving the elderly.

These are important steps that the federal government can take. But the most effective war on crimes against old people must take place locally, as thousands of communities admit that there is a problem and resolve to do something about it.

A few communities have taken special steps to improve police protection of the elderly. Hartford, Connecticut, and the New York City Housing Authority have both experimented with "teen escort" services to help older people get around high-crime areas safely. In Hoboken, New Jersey, closed circuit TV cameras survey high-crime street corners as well as housing projects with many elderly tenants. In Washington, D. C., social workers are assigned to station houses to help the police handle non-crime complaints and problems involving older residents of neighborhoods. The Washington program is particularly interesting, since police are often the first public servants to encounter older people in immediate need of help.

Other agencies and groups are trying to develop new approaches to the problem. The Justice Department in California trains older people in protective crime prevention and the state Attorney General's office has a special advisory committee on problems of the aging. The Department of Housing and Urban Development is studying ways to meet the security needs of older residents in federally-funded housing projects. The American Association of Retired Persons has established training sessions for its local chapters in crime prevention and safety. All this activity is an indication that prevention of crimes against the elderly is starting to get the attention it deserves.

Incompetency Proceedings

Of all the legal proceedings which an older person can become entangled in, probably none has more sweeping effects than an action to declare him incompetent to manage his affairs. Most incompetency actions involve older people; they almost always end in a court judgment placing the older person's property under the control of a guardian. Often—and some legal scholars say "usually"—the older person's "incompetence" merely involves memory loss or ignorance of the ways he can defend himself in court. Those who bring incompetency proceedings are mainly drawn from two groups: potential heirs of the older person's estate, who have an obvious conflict of interest; and state mental hospitals, suing elderly patients to recover the costs of their treatment.

A court declaration of incompetence strips a person of his civil rights. He is prohibited from making decisions about his financial affairs and property. An older person who is declared incompetent is likely to lose his liberty as well. Studies show that most elderly men and women found to be incompetent wind up involuntarily committed to mental hospitals.

The abuses of the incompetency action were documented in a 1968 study of 600 such cases in Central New York State. One man was declared incompetent and committed to a mental hospital because he accused his wife of infidelity. She bore a child out of wedlock while he was in the hospital. Another man was found incompetent because he accused his niece of stealing his diamond ring. His guardian could not find the ring when he examined the man's property. Another man was found to be incompetent after he accused his son of stealing from him. The court appointed his son to serve as his guardian.

The New York study found that older people's property is rarely protected through incompetency proceedings. In the vast majority of the cases studied, the court-appointed guardian rapidly liquidated the older person's estate. By contrast, most estates of younger persons declared incompetent grew in value during the time they were controlled by a guardian.

Abuses flourish because the incompetency proceeding is a one-sided legal action. The older person, or person who is under suspicion, has only minimal legal protection against those who would strip him of his civil rights. Surprising as it may seem, the attorney for the petitioner who wants someone declared incompetent is paid from the estate of the ward. Thus, he usually receives a much larger fee than the attorney for the ward, who is seldom paid from the estate. The Central New York study found that the average petitioner's legal fees were $1,341 for bringing the largely uncontested incompetency action. In contrast, attorneys for the ward were paid an average of $268.

The result of this unequal arrangement is to turn what is theoretically an adversary proceeding into a grave threat to the rights and property of the older individual accused of "incompetence." For example, not one of the 600 findings of incompetence examined in the New York study was ever appealed to a higher court.

Theoretically, of course, the incompetency proceeding is designed to protect the individual who is unable to manage his affairs wisely and who is unaware of or unwilling to admit his deficiency. Such people need legal protection. Yet the more one examines the operation of incompetency proceedings, the more one appreciates the warning of Justice Brandeis:

> Experience should teach us to be most on our guard to protect liberty when the Government's purposes are beneficent....The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning, but without understanding.

Legal scholars, private lawyers, the American Bar Association, and advocates for the elderly have proposed a variety of measures to turn the incompetency action into a genuine adversary proceeding, with full protection for the individual. These measures include mandatory notice, counsel for the accused individual, a full hearing of the evidence, jury trial if necessary, and periodic review of the cases of people found to be incompetent. Another recommendation is to tighten up the loose medical and psychiatric criteria which are often used to substantiate a finding of incompetence. The criteria question is the crucial problem. Legal authorities must devise a definition of incompetence precise enough to both protect individuals whose behavior is merely irritating, and to help those who are genuinely incapable of managing their affairs.

Involuntary Commitment

Many older people who have been found incompetent to manage their personal affairs are also unwilling patients in mental hospitals. They have been committed both before and after the courts have made a judgment of incompetency. Commitment procedures and incompetency actions are strikingly similar. Both are often directed at older people. Both are presumed to be benevolent legal actions to protect individuals who cannot care for themselves. Both suspend normal legal safeguards of an individual's rights. Both rely heavily on psychiatric terminology of little legal precision. Thus, in many states, anyone can be sent to a mental hospital for weeks if someone will petition for his commitment and if two psychiatrists will certify that the individual needs "observation."

In June, 1974, a three-judge federal court struck down Michigan's commitment statute for several deficiencies. A close look at the court's ruling reveals the major problems in involuntary commitment statutes across the country. The now-invalid Michigan statute did not require that the allegedly mentally ill person be notified of the petition against him so he or she could prepare a defense. The court insisted that it must. Neither did the statute require that the individual be notified of his rights to counsel or to a jury trial if desired. The court also struck down language in the law allowing a judge to bar the presence of the accused at the hearing solely on the advice of psychiatrists.

But the federal panel reserved its greatest scorn for the imprecise and broad criteria defining "mental illness." It cited these definitions of mental disturbance from the American Psychiatric Association's diagnostic manual: "Tension headaches or impotence if emotional factors play a causative role. . . Passive-aggressive personality in which the aggressiveness may be expressed by obstructionism, pouting, procrastination, intentional inefficiency or stubbornness." Under these criteria, the court said, virtually all people could be committed to a mental hospital at some time in their lives.

In fact, many legal scholars and even some psychiatrists seriously doubt whether a legal definition of mental illness can be formulated which makes a meaningful distinction between people in mental hospitals and those living in the community. The Braginsky studies suggest that a middle-class bias can be found in the diagnostic patterns of mental health professionals. Left-wing and radical patients are rated as increasingly disturbed the more they complain about social ills. The diagnosis is less severe if the patient complains about radicals and leftists. However, both leftists and conservatives are most likely to be found mentally ill if they criticize psychiatrists.

Thomas Szasz, a well-known psychiatrist and author, doubts that a scientifically valid medical definition of "mental illness" exists at all. He has written that "the person's trouble is not that he has a badly functioning brain, but rather that he is acting in certain ways that other people don't like." Szasz does not deny existence of deviant and disturbing behavior; he merely says that such behavior represents moral or legal problems—not medical illness. The question then changes from "What mental illness does this person have?" to "What can we do about this behavior?"

The court rulings against involuntary commitment and the legal attack on incompetency proceedings exhibit a growing skepticism that treatment of disturbed individuals can do much at all. Commitment and incompetency procedures have been constructed on the assumption that involuntary treatment in a mental hospital and appointment of a guardian to manage one's affairs are basically in the individual's best interests. Now the law is not so sure. The American Bar Association recommends that incompetency hearings be turned into true adversary proceedings, with full protection for the accused individual. A federal court demands the same thing for Michigan's commitment statutes. The assumption in both cases is that the cure is often worse than the problem.

II
THE LAW AS HELPER

Advocacy

Although the lawyer is popularly conceived as a dashing figure in the courtroom, lawyers usually hate to see their clients' cases coming before a judge and jury. They would much rather settle cases out of court—in a hearing, by administrative action, through persuasion in meetings, on the telephone, or by correspondence. Advocates for the poor, especially, find that the threat to sue is often more effective than the suit itself.

Many lawyers representing older people have found the administrative settlement option particularly effective when their clients are caught in the workings of an unresponsive, but not necessarily malevolent, bureaucracy. For example, legal service attorneys in Los Angeles persuaded the city to drop plans to turn a park largely used by old people into a parking lot. Attorneys in Miami and Washington, D. C. successfully petitioned city authorities to lower public transportation fares for old people. Other advocates have persuaded public housing authorities to provide more police or special security forces in public housing for the elderly.

Old people most in need of this kind of resourceful legal representation are those receiving welfare or other payments from public programs. These individuals ordinarily have the greatest personal needs, are least likely to know their rights, and are also least likely to fight back when the bureaucracy wrongs them. A good example of effective representation of the elderly poor occurred in the early 1970s in Boston when welfare officials routinely denied a client's request for money to buy false teeth. The man went to a legal advocate working in a Legal Research and Services for the Elderly project, funded by the Office of Economic Opportunity through the National Council on the Aging. The advocate dug into the case and eventually overturned the decision in an administrative hearing. He argued that the denial of the old man's false teeth was not only inhumane, but would probably cost the public more in the long run, if, as was likely, it eventually caused the man's health to fail. Such cases are well worth an advocate's time, for they have the potential for making permanent changes in a bureaucracy's policies and methods of operation.

Other cases have an impact only on a single individual who has been hurt. In New York, an older woman left a nursing home after a 99-day stay, and was informed that Medicare would not cover her expenses, as she had thought. In Georgia, a Social Security office denied a widow's attempt to be certified as disabled because a physician's statement was not properly worded. Both decisions were later successfully appealed by legal aid attorneys who were familiar with the relevant regulations and appeals procedures. But such work is often among the most complex and frustrating that lawyers can undertake. Says Morris M. Goldings, a Boston attorney who works with many old people: "The exquisite distinctions which can be woven by interested lawyers from subsections of regulations relating to Medicare and Medicaid would leave the anti-trust lawyer and the most sophisticated tax lawyers at the starting gate."

Lawyers working with poor elderly have helped thousands of people cope with confusion and administrative problems associated with the implementation of the Supplemental Security Income (SSI) program. In testimony before the U. S. Senate Special Committee on Aging, James A. Bensfield of the National Senior Citizens Law Center described some of these problems. They included wildly fluctuating SSI payments, drastic reductions in payments, late checks, and checks stopping without notice. Most of these problems have no explanation except that they are mistakes made by "those damned computers in Baltimore." Bensfield told the Senate Committee that most officials he dealt with about such problems were very understanding and would do everything they could to help. But meanwhile, many old people have turned to legal service attorneys for help.

In one case, an elderly SSI recipient and his attorney spent hours with Social Security officials in Boston trying to discover why the man did not receive regular SSI payments despite his certified eligibility. With his attorney's help, the man received emergency payments for seven consecutive months before he was placed permanently on the eligibility rolls. In another case in Maine, the computer denied another man's application for disability benefits before he could even be examined by a doctor. The disabled man had to seek an attorney's help to enter a long and slow appeals process. (One may well be suspicious of administrators' easy tendency to blame mistakes on "damned computers." Every machine error is caused by a human error. Those who work with computers have an acronym for it: G.I.G.O., meaning, "garbage in, garbage out.")

Consumer Issues

When older people function as consumers, they have many good reasons to be exceedingly careful. A major cause for caution is the well-known fact that older consumers must cope with a raging inflation on a relatively fixed income. Inflation has eaten up most of the 75 percent increase in Social Security old age benefits that occurred between 1965 and 1975. Furthermore, old people spend most of their income on food, housing, medical care, and transportation—four items which have been feeling inflationary pressures very strongly.

But old people are vulnerable to a large number of other consumer frauds and inequities. They are frequently defrauded by quack medicine hustlers, land swindles, and phony home improvement schemes. These schemes often follow the news very closely. For example, in the energy crisis of 1974, the U. S. Postal Service warned older people against questionable mail-order promotion of furnaces and insulation "specials." Other swindles exploit the circumstances of being old. Two major examples of this include fraudulent "cures" for arthritis and shoddy practices in the sale and fitting of hearing aids. Finally, old people are as vulnerable as anyone else to the straight marketplace rip-off—the new refrigerator that fails to work, the sofa with a scratch on the side, the auto repairs that are not done. In a growing number of cases, older victims of such frauds are seeking legal relief. They are going to court to recover damages and sometimes seeking new legislation to tighten controls on unscrupulous merchants and confidence men.

However, an aggrieved consumer of any age who tries to sue a merchant without legal help is likely to have problems. Often, court clerks are unwilling to help a legally-inexperienced consumer fill out the forms necessary to file a suit. Court officers also often neglect to explain how an opposing counsel can delay a suit, thus causing the consumer to miss work, come to court, and find the case postponed. When an accused merchant is represented by counsel, judges must adhere to strict rules of evidence, often preventing the consumer from telling his whole story. Finally, many states require both sides in an appeal to be represented by counsel. Thus, a merchant can frequently turn a defeat into a victory by simply filing a notice of appeal. Many consumers, unable to afford a lawyer, will give up.

Recognizing these problems, some cities and states have established efficient, streamlined small claims court systems that prohibit merchant-defendants in consumer suits from retaining an attorney. The consumer and the defendant tell their stories to a hearing examiner who attempts to arbitrate a settlement. Failing that, both parties repeat their stories to a judge, who then decides the issue. However, such streamlined small claims court systems are relatively rare.

One of the major problems in old age consumerism is the reluctance of many older people to seek help. Often old people do not even know that a home repair salesman or other hustler has defrauded them. If they do know, many older people are too embarrassed to object. There are some signs that this attitude is changing, and that the consumer movement has begun to make some small inroads among older people.

The most recent sign of change was the creation of a Retired Professional Action Group, an association of retired professionals formed under the umbrella of the Ralph Nader organization. Recently, the RPAG issued a 300-page report calling for regulation and reform of the hearing aid industry. The group charged that many hearing aid dealers are unqualified to fit devices properly, and that the average $350 to $400 charge for a hearing aid is exorbitantly high.

Advocates for the elderly have also started drawing attention to arthritis quackery—another swindle which especially affects older people. The Arthritis Foundation estimates that quack claims promising "cures" for arthritis bilk suffering people of more than $400 million annually. The Foundation points out that arthritis can often be controlled, but never cured.

The U. S. Senate Special Committee on Aging has proposed legislation to protect older people from the injustices of condominium conversion—one of the hottest trends in the real estate business. Many of the stately old apartment buildings which are prime candidates for conversion into condominiums are inhabited by older tenants. The high cost of improvements often raises the rent beyond the reach of older tenants who want to remain in the building. Older people often do not have the down payment to purchase a condominium, and lenders usually hesitate to give a mortgage to someone over 60 years old. Too often, an old tenant of a building being converted into condominiums is faced with a notice to buy a condominium or vacate his apartment within 30 days.

In scattered instances, legal advocates are taking direct action to press the claims of older consumers before commissions which set utility, telephone, and transportation fees. The Massachusetts case described earlier, where the state's Department of Public Utilities agreed to entertain a proposal that would grant a 50 percent rate reduction to every telephone subscriber over age 62, suggests the broad potential for such legal action.

III

PROVIDING LEGAL SERVICES TO THE ELDERLY

Most legal services in the United States are provided by private attorneys in private law firms. Corporations, unions, individual clients, and other interests can usually obtain highly effective legal representation if they have the financial resources to pay for it. Many poor people can also obtain excellent help from lawyers organized in community legal service groups, funded through the federal Legal Services Corporation. However, the cost and organization of the private bar prevents most middle-class and many poor people from enjoying the benefits of legal help. Thomas O'Toole, dean of the Northeastern University Law School in Boston, described the problem to the U. S. Senate Special Committee on Aging in these blunt terms: "We've tolerated a situation in which virtually all of our legal services are made available to those who need them least and almost no legal services made available to those who need them most."

For many people, the minimum fee schedule adopted by most bar associations and their members closes access to legal relief. For example, few people can sue to recover damages on a defective $300 refrigerator because the lawyer's fee is higher than any amount that could be recovered in a suit. Comments Ralph Nader: "The law has never gone in for economies of scale. It's as if you couldn't buy a car for less than $20,000." Some bar associations have backed away from the minimum fee schedules after a lawyer in the Nader organization won a federal suit challenging the practice in a Virginia county. The American Bar Association, under pressure from some of its members, is studying ways to open legal service to the middle class at a reasonable cost.

Affluent older people have always been able to find a good lawyer. Increasingly, poor elderly can find one too, if they live in a region served by an office of the federally-funded Legal Services Corporation. Legal Services attorneys will handle most legal affairs of poor people free of charge. They will not handle defense in criminal prosecutions—the responsibility of public defenders—nor will some offices handle divorces, if these can be obtained at a reasonable cost from private attorneys. Since poor people have serious legal problems and can rarely obtain help from private attorneys, legal service representation is a breakthrough of major significance.

However, the potential of legal service programs for the elderly poor remains largely unfilled. A survey of nearly a hundred service programs found that the poverty lawyers themselves doubted that they were meeting the legal needs of older people. More than half the agencies said flatly that they did not meet the needs of old people in their communities. Of the 30 agencies who thought they were serving older poor people adequately, only 10 actually served a percentage of the elderly equal to or exceeding the percentage in their communities. The reasons for this situation are familiar ones: older people are unlikely to demand service, and agencies staffed and dominated by the young are unlikely to assign a high priority to the needs of the old.

Those legal service agencies which do serve a large number of poor older clients typically employ special measures to publicize the agency and to encourage older people to use it. Such steps include special leaflets, posters, and media publicity aimed at older people; formal relationships with local senior citizens groups; and close cooperation with other community agencies in regular contact with the poor elderly. However, such outreach efforts are limited. The agencies providing legal services to the poor are typically underfinanced, and staff attorneys are typically burdened by excessive caseloads. The majority of legal service programs provide no special means of reaching the elderly poor to inform them of available services. For new clients, they rely on "word of mouth" publicity and referrals from other agencies.

Expansion of legal services to the poor as well as non-poor elderly depends on the success of other proposals. These ideas seek to uncover new sources of money to support legal service to the elderly, to encourage lawyers and law students to become interested in their needs, and to create new structures to provide legal services more effectively to the old.

A crucial need is trained legal manpower—lawyers, law students, and paralegal aides who will work for the elderly. Some of these persons can be convinced to devote part of their time without pay to the needs of the elderly. Others may be supported directly or indirectly by their law firms and other employers. Many firms are agreeing to release some of their attorneys' time each week or month for community service work. More extensive financial support for full-time workers is potentially available from private foundations, bar associations, law firms, several agencies of the federal government, and state units on aging.

This legal talent can be sought in hitherto neglected places. In connection with courses and student organizations, many law students spend part of their time serving people who cannot afford legal service. Many would be responsive to suggestions that old people are deserving of their help. Retired and semi-retired lawyers often have a personal interest in the legal problems of the elderly, and can communicate with older clients effectively as well. One possible model for providing legal services to older people might be to enlist law students and place them under the supervision of older semi-retired attorneys, law professors, or private attorneys who devote part of their time to work in the community.

Such legal manpower might be organized in new ways. In some places, it might serve older people through a local senior citizens' organization, a senior center, or other group which could provide a central location and possibly some degree of financial support. Elsewhere, the local Legal Services program might set up a special unit which specializes in service to the elderly.

The use of non-lawyers to serve the legal needs of older people is one strategy which has particular promise. Its potential has been demonstrated in Santa Cruz, California, an area with a large number of elderly poor residents. In Santa Cruz, three elderly "paralegal" advocates, working under the part-time supervision of a lawyer, managed to reach four times as many older people in one year as had been previously served by the area's Legal Services program.

In summary, such proposals for reform suggest that the older person's relationship with the law is changing. Correction of legal abuses and expansion of legal rights may well mark major accomplishments in the future.

REFERENCES AND FURTHER READING

The references listed on the following pages have been chosen primarily to guide the reader into further study of the material presented in this book. The references are listed by chapter, and most are introduced by a short explanation of key books. Many of the references are also annotated —another measure intended to help the reader's further reading. Finally, these lists of references are deliberately and necessarily selective. Many of the items selected for special attention in these references have been chosen at least partly because they contain comprehensive bibliographies. There is little need to reproduce here the bibliographies available in such books as Riley's *Aging and Society*, the Tibbitts and Birren *Handbooks*, Eisdorfer and Lawton's *The Psychology of Adult Development and Aging*, and the White House Conference on Aging background papers. By following the leads suggested in these references and by consulting the books listed in the Appendix, the curious reader should gain access to all material relevant to his area of interest.

CHAPTER 1
A PERSPECTIVE ON AGING

The perspective on aging presented in Chapter 1 is the author's. With the exception of the Tibbitts citation which begins the chapter and whose source is forgotten, material referred to is presented below.

Cumming, Elaine, and Henry, William. *Growing Old*. New York: Basic Books, 1961.
The presentation of disengagement theory.

Curtin, Sharon. *Nobody Ever Died of Old Age*. Boston: Little, Brown, and Co., 1972.
A feminist's angry look at the way our society treats older people.

De Beauvoir, Simone. *The Coming of Age.* New York: Putnam, 1972.
See note describing this book in the Appendix.

Groult, Benoîte. *La Part des Choses.* Paris: Grasset, 1972.

Kastenbaum, Robert. "What Happens to the Man Who is Inside the Aging Body?" Duke Council on Aging and Human Development. *Proceedings of Seminars. 1965-69.* Durham, N.C.: Duke University Press, 1969. Reprinted in *Perspectives on Aging. Vol. II: Operational Focus.* Frances Scott, ed. Eugene, Ore.: Oregon Center for Gerontology, 1971.

Neugarten, Bernice L., et al. *Personality in Middle and Late Life.* New York: Atherton Press, 1964.
See references to Chapter 5 for a description of this book and others describing developmental theory.

Philibert, Michel. "Philosophies of Aging." Ann Arbor: Institute of Gerontology, The University of Michigan-Wayne State University. In Press.

Rose, Arnold. "The Subculture of Aging: A Framework for Research in Social Gerontology." In, *Older People and Their Social World.* A. Rose and W. Peterson, eds. Philadelphia: F. A. Davis, 1965.
Older people as a subculture.

CHAPTER 2
PHYSIOLOGICAL AND BIOLOGICAL CHANGES

Patterns of Physiological Aging

The literature of physiological aging includes both book-length studies and summary descriptions within books covering a broader field. Some of these are listed below.

Comfort, Alex. *The Process of Aging.* New York: New American Library, 1964.

Milne, Lorus J. and Milne, Margery. *The Ages of Life.* New York: Harcourt, Brace and World, 1968.

Shock, Nathan W. *Biological Aspects of Aging.* New York: Columbia University Press.

Smith, Elliott Dunlap. *Handbook of Aging.* New York: Barnes and Noble Books, 1972.

The Search for Longevity

Leaf, Alexander. "Getting Old." *Scientific American.* Vol. 229, No. 3. September, 1973. pp. 45-52.
Summary of the author's studies in three areas where longevity is common.

Rosenfeld, Albert. "The Longevity Seekers." *Saturday Review of the Sciences*. Vol. 1, No. 2, February 24, 1973.
Popular article about longevity.

Strehler, Bernard L. "Lengthening Our Lives." Beverly Hills, Calif.: Aging Research Institute of America, 1973.
A biologist who believes we may someday conquer aging discusses the state of anti-aging research.

CHAPTER 3
PSYCHOLOGICAL CHANGES

To pursue a topic in the psychology of aging, the student should first consult *The Psychology of Adult Development and Aging* (1973), edited by Eisdorfer and Lawton. Articles in this book summarize the progress of research in experimental, developmental, and clinical psychology. Each article contains a complete bibliography. Articles particularly relevant for this chapter include Arenberg's "Cognition and Aging"; Baltes and Labouvie's "Adult Development of Intellectual Performance"; and Kastenbaum's "Loving, Dying, and Other Gerontologic Addenda."

The Eisdorfer and Lawton volume updates some parts of Birren's *Handbook of Aging and the Individual* (1959). However, the *Handbook* remains the most comprehensive one-volume review of age-related psychological changes. Among the topics covered are sensory functions, perceptual processes, psychomotor performance, age and learning, intelligence and problem-solving, drives and emotions, and personality theory. Birren also reviewed this material in *The Psychology of Aging* (1964). A final and briefer review of psychological research is found in Volume I of *Aging and Society* (1968) by Riley and Foner.

General References

Birren, James E., ed. *The Handbook of Aging and the Individual*. Chicago: University of Chicago Press, 1959.

Birren, James E. *The Psychology of Aging*. Englewood Cliffs, N.J.: Prentice-Hall, 1964.

Donahue, Wilma T. "Psychological Changes With Advancing Age." In *Planning Welfare Services for Older People*. Washington, D.C.: Department of Health, Education, and Welfare, 1965.

Eisdorfer, Carl and Lawton, M. Powell. *The Psychology of Adult Development and Aging*. Washington, D.C.: American Psychological Association, 1973.

Riley, Matilda and Foner, Anne. *Aging and Society. Vol. I: An Inventory of Research Findings*. New York: Russell Sage Foundation, 1968.

Drives

Lobsenz, Norman M. "Sex and the Senior Citizen." *The New York Times Magazine*. January 20, 1974.

Masters, William H. and Johnson, Virginia E. *Human Sexual Response.* Boston: Little, Brown and Co., 1966.

Intelligence and Learning

Baltes, Paul B. and Schaie, K. Warner. "Aging and IQ: The Myth of the Twilight Years." *Psychology Today.* Vol. 7, No. 10, March, 1974.
A summary of the long-term study of intelligence changes with age, written in an easily-accessible style.

Riegel, Klaus and Riegel, Ruth. "Development, Drop, and Death." *Developmental Psychology.* Vol. 6, No. 2 pp. 306-319, March 1972.
The findings about the "terminal drop" in intelligence preceding death.

McClusky, Howard Y. *Education.* Background paper for the 1971 White House Conference on Aging. Washington: The Administration on Aging, 1970.

Creativity

Abelson, Philip H. "Revitalizing the Mature Scientist." Editorial in *Science.* 141:597, August 16, 1963.

Lehman, Harvey C. *Age and Achievement.* Princeton: Princeton University Press, 1953.

Death

Kastenbaum, Robert and Aisenberg, R. B. *The Psychology of Death.* New York: Springer, 1972.

Kübler-Ross, Elisabeth. *On Death and Dying.* New York: Macmillan, 1969.

Morison, Robert S. "Dying." *Scientific American.* Vol. 229, No. 3, Sept. 1973.

CHAPTER 4
SOCIOECONOMIC CHANGES

Several parts of this chapter are discussed in greater detail elsewhere in the book. The reader is referred to Chapter 6 for a more detailed treatment of retirement and retirement roles, and to Chapter 10 for an expanded treatment of income changes with age. Other material used in this chapter is listed here.

Demographic and Cultural Changes

Brotman, Herman. *Facts and Figures on Older Americans.* Nos. 1-10. Washington, D.C.: Administration on Aging, 1973.
Ten pamphlets which summarize the older population as it appears in the 1970 Census.

Brotman, Herman. *Who are The Aged: A Demographic View.* Occasional Paper in Gerontology No. 1. Ann Arbor: Institute of Gerontology, The University of Michigan-Wayne State University, 1967.
Another Brotman profile of the older population.

Hauser, Philip. "Extension of Life: Demographic Considerations." Ann Arbor: The Institute of Gerontology, The University of Michigan-Wayne State University. In press.

Socioeconomic Changes

Blau, Zena Smith. *Old Age in a Changing Society.* New York: New Viewpoints, 1973.
An application of sociological methodology to aging and older people. The author's essay on role exit is particularly intriguing.

Rosow, Irving. "Old Age: One Moral Dilemma of an Affluent Society." *The Gerontologist.* 2(1962) pp. 182-191.

Tibbitts, Clark. "Origin, Scope, and Fields of Social Gerontology." In *Handbook of Social Gerontology.* Clark Tibbitts, ed. Chicago: University of Chicago Press, 1961.
A theoretical essay on socioeconomic age changes.

Tibbitts, Clark. "Middle-Aged and Older People in American Society." In *Planning Welfare Services for Older People.* Washington, D.C.: Department of Health, Education, and Welfare, 1965.

CHAPTER 5
ADJUSTING TO AGING

Five Adaptive Tasks

Clark, Margaret and Anderson, Barbara. *Culture and Aging.* Springfield, Ill.: Charles C. Thomas, 1967.

Personality in Later Life

Neugarten, Bernice L. "Personality Change in Late Life: A Developmental Perspective." In *The Psychology of Adult Development and Aging.* Carl Eisdorfer and M. Powell Lawton, eds. Washington, D.C.: American Psychological Association, 1973.
Those wishing to study personality in old age should begin here. Neugarten's essay summarizes research in this still-underdeveloped field and her bibliography is very extensive.

Neugarten, Bernice L., et al. *Personality in Middle and Late Life.* New York: Atherton Press, 1964.
The major papers and studies flowing from the Kansas City Studies of Adult Life. Chapter 9 offers a good summary of the developmental theory of aging.

Reichard, Suzanne, Livson, F., and Peterson, P. *Aging and Personality.* New York: John Wiley and Sons, 1962.
A flawed but useful study of personality types among older men.

Riegel, Klaus F. "Personality Theory and Aging." In *The Handbook of Aging and the Individual.* James E. Birren, ed. Chicago: University of Chicago Press, 1959.

Attitudes Toward Aging

Bennett, Ruth and Eckman, Judith. "Attitudes Toward Aging: A Critical Examination of Recent Literature and Implications for Future Research." In *The Psychology of Adult Development and Aging.* Carl Eisdorfer and M. Powell Lawton, eds. Washington, D.C.: American Psychological Association, 1973.
The title of the essay is self-explanatory. A useful essay with an excellent bibliography.

Kogan, Nathan and Shelton, Florence C. "Beliefs About 'Old People': A Comparative Study of Older and Younger Samples." *Journal of Genetic Psychology.* 1962, 100, pp. 93-111.
The sentence-completion test, showing that old and young view each other very differently.

CHAPTER 6
ADJUSTING TO RETIREMENT

The literature on retirement and its challenges is voluminous. Sociologists, economists, gerontologists, and educators have all examined the subject in what is probably the best example of inter-disciplinary scrutiny in the field of aging. Riley and Foner establish the base of data in their *Inventory of Research Findings.* In their background papers for the 1971 White House Conference on Aging, Schulz and Streib survey retirement and retirement roles from the viewpoint of economics and public policy.

Barfield, Richard, and Morgan, James. *Early Retirement: The Decision and the Experience.* Ann Arbor: Institute for Social Research, 1969.
A study of auto workers. Shows the interplay between health and income as factors in the retirement decision.

Carp, Frances, ed. *Retirement.* New York: Behavioral Publications, 1972.
Papers studying retirement from a multitude of angles, mixing academic and popular styles.

Chen, Yung-Ping. *Income.* Background paper for the 1971 White House Conference on Aging. Washington, D.C.: Administration on Aging, 1970.
Economic analysis of income after working days end.

Donahue, Wilma; Orbach, Harold; and Pollak, Otto. "Retirement: The Emerging Social Pattern." In *Handbook of Social Gerontology.* Clark Tibbitts, ed. Chicago: University of Chicago Press, 1961.
A valuable essay examining retirement from a sociological perspective.

Hunter, Woodrow W. *Preparation for Retirement.* Ann Arbor: Institute of Gerontology, The University of Michigan-Wayne State University, 1973.
A small book aimed at use in preretirement classes. See description in Appendix.

Orbach, Harold L. et al. *Trends in Early Retirement.* Occasional Paper in Gerontology No. 4. Ann Arbor: Institute of Gerontology, The University of Michigan-Wayne State University, 1970.

Peterson, David A. *The Crisis in Retirement Finance: The Views of Older Americans.* Occasional Paper in Gerontology No. 9. Ann Arbor: Institute of Gerontology, The University of Michigan-Wayne State University, 1971.
A study of how older people see their own economic needs in retirement, a question few investigators have asked.

Riley, Matilda W. and Foner, Anne. *Aging and Society. Vol. I: An Inventory of Research Findings.* New York: The Russell Sage Foundation, 1968.
An essential resource for the student of retirement. Chapter 3 summarizes research findings about the labor force participation of men and women, work patterns, characteristics of older workers, factors associated with retirement, and social patterns of leisure.

Schulz, James. *Retirement.* Background paper for the 1971 White House Conference on Aging. Washington, D.C.: Administration on Aging, 1970.

Shanas, Ethel. *Old People in Three Industrial Societies.* New York: Atherton Press, 1968.
Shows that Americans view retirement in uniquely American ways.

Streib, Gordon F. *Retirement Roles and Activities.* Background paper for the 1971 White House Conference on Aging. Washington, D.C.: Administration on Aging, 1970.

CHAPTER 7
THE OLDER PERSON IN THE COMMUNITY

This sprawling chapter covers topics as diverse as widowhood and participation of older people in political organizations. At each point, the reader may consult Riley and Foner's *Inventory of Research Findings* for a useful summary of what social scientists know about an area, as well as for a bibliography of the research studies themselves. Three White House Conference background papers—those by Binstock, Cottrell, and Morris—draw public policy implications from this material. The reader is also referred to Volume II of Riley's *Aging and Society, Aging and the Professions,* and to Tibbitts's *Handbook of Social Gerontology,* for material relevant to this chapter.

Family Relationships

Kerckhoff, Alan C. "Nuclear and Extended Family Relationships: A Normative and Behavioral Analysis." In *Social Structure and the Family: Generational Relations.* Ethel Shanas and Gordon Streib, eds. Englewood Cliffs, N.J.: Prentice-Hall, 1965.
The study of the family relationships of older people.

Rosow, Irving. *Social Integration of the Aged.* New York: The Free Press, 1967.
An important study of the inter-personal and familial relationships of the elderly.

Riley, Matilda W. and Foner, Anne. *Aging and Society. Vol. I: An Inventory of Research Findings.* New York: The Russell Sage Foundation, 1968.
Chapters 23 and 24 survey research into older people's relationships with family and friends.

Community Associations and Political Behavior

Carlie, Michael K. "The Politics of Age: Interest Group or Social Movement?" *The Gerontologist.* 9:4(I), 1969.

Cottrell, W. Fred. "Governmental Functions and the Politics of Age." In *Handbook of Social Gerontology.* Clark Tibbitts, ed. Chicago: University of Chicago Press, 1961.
Discusses both the early organization of government to serve the elderly and possible impact of older people as a political interest group.

Donahue, Wilma and Tibbitts, Clark, eds. *The Politics of Age.* Ann Arbor: The University of Michigan Press, 1962.

Glenn, Norval D. "Aging, Disengagement, and Opinionation." *Public Opinion Quarterly.* 33:17-33. 1969.

Glenn, Norval D. and Grimes, Michael. "Aging, Voting, and Political Interest." *American Sociological Review.* 33:563-75. 1968.
The two Glenn articles are useful studies of older people's voting patterns, political opinions, and attitudes toward the political process.

Hammond, Phillip. "Aging and the Ministry." In *Aging and Society. Vol. II: Aging and the Professions.* Matilda W. Riley, et al., eds. New York: The Russell Sage Foundation, 1969.
An essay on religious organizations' service to older people, and what research findings suggest they should be doing.

Maves, Paul B. "Aging, Religion, and the Church." In *Handbook of Social Gerontology.* Clark Tibbitts, ed. Chicago: University of Chicago Press, 1961.
A summary article covering Judeo-Christian teachings about old age, history of the care of old people by religious groups, and programs for older people in local congregations.

Moberg, David O. "Religiosity in Old Age." *The Gerontologist.* 5(2). 1965.

Riley, Matilda W. and Foner, Anne. *Aging and Society. Vol. I: An Inventory of Research Findings.* New York: The Russell Sage Foundation, 1968.
See Chapters 19 and 20 for a summary of research findings about older people's political and religious roles.

Riley, Matilda W.; Riley, John W.; and Johnson, Marilyn E., eds. *Aging and Society. Vol. II: Aging and the Professions.* New York: The Russell Sage Foundation, 1969.
This book consists of essays about professional groups' responsibilities to older people. See especially Robert Morris's "Aging and the Field of Social Work."

Service Delivery

Binstock, Robert. *Planning.* Background paper for the 1971 White House Conference on Aging. Washington, D.C.: Administration on Aging, 1970.

Cottrell, W. Fred. *Government and Non-Government Organization.* Background paper for the 1971 White House Conference on Aging. Washington, D.C.: Administration on Aging, 1970.

Institute of Gerontology, The University of Michigan-Wayne State University. *Minority Aged in America.* Occasional Paper in Gerontology No. 10. Ann Arbor: Institute of Gerontology, 1971.
See Elias S. Cohen's "Welfare Policies for the Aged Poor: A Contradiction" and Donald P. Kent's "Changing Welfare to Serve Minority Aged."

Morris, Robert. *Facilities, Programs, and Services.* Background paper for the 1971 White House Conference on Aging. Washington, D.C.: Administration on Aging, 1970.

CHAPTER 8
ETHNIC AND OTHER MINORITIES

Benedict, Robert. "A Profile of Indian Aged." In *Minority Aged in America.* Occasional Paper in Gerontology No. 10. Ann Arbor: Institute of Gerontology, The University of Michigan-Wayne State University, 1971.

Birren, James E. "The Aged in Cities." *The Gerontologist.* 9(3, part I), 1969.

Hill, Robert B. "A Profile of Black Aged." In *Minority Aged in America.* Occasional Paper in Gerontology No. 10. Ann Arbor: Institute of Gerontology, The University of Michigan-Wayne State University, 1971.

Jackson, Jacquelyne J. "Compensatory Care for Black Aged." In *Minority Aged in America.* Occasional Paper in Gerontology No. 10. Ann Arbor: Institute of Gerontology, The University of Michigan-Wayne State University, 1971.

Kalish, Richard A. and Yuen, Sam. "Americans of East Asian Ancestry: Aging and the Aged." *The Gerontologist.* 11(1, part II), 1971.

Kent, Donald. "The Negro Aged." *The Gerontologist.* 11(1, part II), 1971.

Lindsay, Inabel B. *The Multiple Hazards of Age and Race: The Situation of Aged Blacks in the United States.* Study for the U.S. Senate Special Committee on Aging. Washington, D.C.: U.S. Government Printing Office, 1971.

National Urban League. *Double Jeopardy: The Older Negro in America Today.* New York: National Urban League, 1964.

U.S. Senate Special Committee on Aging. *Developments in Aging: 1973 and January-March 1974.* Washington, D.C.: The Senate Special Committee on Aging, 1974.
Chapter 11 contains a useful compilation of data on minority old age poverty.

White House Conference on Aging. *Toward a National Policy on Aging. Vols. I and II.* Washington, D.C.: U.S. Government Printing Office, 1971.
Volume II of the Conference's final report includes reports and recommendations from sessions on minorities, rural elderly, and the elderly blind and disabled.

CHAPTER 9
MALADJUSTMENT

Busse, Ewald W. and Pfeiffer, Eric, eds. *Behavior and Adaptation in Late Life.* Boston: Little, Brown and Co., 1969.
Contains several very useful articles on mental disorders.

Busse, Ewald W. and Pfeiffer, Eric, eds. *Mental Illness in Later Life.* Washington, D.C.: American Psychiatric Association, 1973.
Articles about the causes, diagnosis, and treatment of mental disorders in old age. Edited for the practicing physician and non-specialists in mental illness.

Butler, Robert N. and Lewis, Myrna I. *Aging and Mental Health.* St. Louis: The C. V. Mosby Co., 1973.
Aspects of mental health in later life, written for those who work with older people.

Eisdorfer, Carl and Lawton, M. Powell, eds. *The Psychology of Adult Development and Aging.* Washington, D.C.: American Psychological Association, 1973.
A large section of this book is devoted to clinical psychology. Specialists may wish to consult the articles by Gurland, "A Broad Clinical Assess-

ment of Psychopathology in the Aged"; Gottesman et al., "Psychosocial Treatment of the Aged"; Kramer et al., "Patterns of Use of Psychiatric Facilities by the Aged: Past, Present, and Future"; and Mensh, "Community Mental Health and Other Health Services for the Aged." Each article ends with an exhaustive bibliography.

CHAPTER 10

ECONOMIC SECURITY IN LATER LIFE

Good sources of general information about the economics of later life are government publications. These include Chen's background paper on *Income* for the 1971 White House Conference on Aging, and two Senate Committee on Aging reports: the massive 2000-page *Economics of Aging* (1970) and the Annual *Developments in Aging*. Once again, the Riley and Foner *Inventory of Research Findings* offers probably the best entree to the subject. Chapter 4 covers the finances of later life in considerable depth. Shanas's *Old People in Three Industrial Societies* provides good comparison material.

General References

Chen, Yung-Ping. *Income*. Background paper for the 1971 White House Conference on Aging. Washington, D.C.: The Administration on Aging, 1970.

Riley, Matilda and Foner, Anne. *Aging and Society. Vol I: An Inventory of Research Findings*. New York: The Russell Sage Foundation, 1968.

Shanas, Ethel. *Old People in Three Industrial Societies*. New York: Atherton Press, 1968.

U.S. Senate Special Committee on Aging. *Developments in Aging: 1973 and January-March: 1974*. Washington, D.C.: The Senate Special Committee on Aging, 1974.

U.S. Senate Special Committee on Aging. *Economics of Aging: Toward a Full Share in Abundance*. Washington, D.C.: U.S. Government Printing Office, 1970.

Pensions

Schulz, James H. *Pens[illegible] Aspects of the Economics of Aging: Present and Future Roles of Private Pensions*. Washington, D.C.: U.S. Government Printing Office, 1970.

SSI

Bensfield, James A. Testimony before the U.S. Senate Special Committee on Aging, July 15, 1974. Washington, D.C.: The Senate Special Committee on Aging.

Burke, Vincent J. and Burke, Vee. "The Minimum Income Revolution." *The Progressive*. Vol 37, No. 12. pp. 33-6. December, 1973.
A good summary of the significance of Supplemental Security Income for the elderly poor.

Social Security

Booth, Philip. *Social Security in America*. Policy Papers in Human Resources and Industrial Relations No. 19. Ann Arbor: Institute of Labor and Industrial Relations, The University of Michigan-Wayne State University, 1973.
A succinct analysis and summary of the major issues in Social Security.

Cohen, Wilbur J. "Social Security is Safe, Sound, and Working." Washington, D.C.: *Congressional Record. Vol. 120, No. 107*. July 18, 1974.
An architect of Social Security (and former HEW Secretary) persuasively defends the system against its critics.

Institute of Gerontology, The University of Michigan-Wayne State University. *Social Security: The First Thirty-Five Years*. Occasional Paper in Gerontology No. 7. Ann Arbor: Institute of Gerontology, 1971.
Six papers on various aspects of the Social Security system. See especially Wilbur Cohen's "Social Security: The First Thirty-Five Years" and Alvin Schorr's "Are We Finished With Social Security?"

Johnson, Richard E. "Social Security: Still a Good Value." Washington, D.C.: The Social Security Administration. Mimeo.
An insurance economist examines the system. This paper may also be available from local Social Security offices.

Miller, Roger Leroy. "Social Security: The Cruelest Tax." *Harper's* Vol. 248, No. 1489. pp. 22-27. June, 1974.
A critic of Social Security identifies some problems with the system.

Schulz, James H. "International Trends in Social Security Reform." Ann Arbor: Institute of Gerontology, The University of Michigan-Wayne State University. In press.

CHAPTER 11
HEALTH CARE

Much of the data presented in this chapter is taken from Riley and Foner's *Inventory of Research Findings*. This data is discussed and somewhat updated in Chin's background paper *Physical and Mental Health* for the 1971 White House Conference on Aging. Figures regarding federal programs are largely drawn from two U.S. Senate Special Committee on Aging publications: *Developments in Aging: 1973* and *Health Aspects of the Economics of Aging* (1970).

Physical Health

Chin, Austin B., Colby, Edwin S., and Robins, Edith G. *Physical and Mental Health.* Background paper for the 1971 White House Conference on Aging. Washington, D.C.: Administration on Aging, 1970.

Coe, Rodney M., and Brehm, Henry P. *Preventive Health Care for Adults.* New Haven: College and University Press, 1972.
Chapter 5 contains the disturbing findings about the prevalence of physicians' mistakes in diagnosing illnesses of older people.

Riley, Matilda and Foner, Anne. *Aging and Society. Vol I:An Inventory of Research Findings.* New York: The Russell Sage Foundation, 1968.

Strauss, Anselm. "Chronic Illness." *Society.* Vol. 10, No. 6. pp. 33-39. September/October, 1973.

U.S. Department of Health, Education, and Welfare, Food and Drug Administration. "A Study of Health Practices and Opinions." Washington, D.C.: National Technical Information Service, 1972.
The HEW study showing a high degree of misinformation about health needs and practices among Americans.

U.S. Senate Special Committee on Aging. *Developments in Aging: 1973 and January-March: 1974.* Washington, D.C.: The Senate Special Committee on Aging, 1974.
See especially Chapter 3, "Health: Containing Costs and Assuring Quality."

U.S. Senate Special Committee on Aging. *Health Aspects of the Economics of Aging.* Washington, D.C.: The U.S. Government Printing Office, 1969.

Mental Health

Busse, Ewald and Pfeiffer, Eric., eds. *Behavior and Adaptation in Later Life.* Boston: Little, Brown and Co. 1969.
See note for this book in references for Chapter 9.

Busse, Ewald W., and Pfeiffer, Eric., eds. *Mental Illness in Later Life.* Washington, D.C.: American Psychiatric Association, 1973.
See note for this book in references to Chapter 9.

Butler, Robert N. and Lewis, Myrna I. *Aging and Mental Health.* St. Louis: The C. V. Mosby Co., 1973.
See note for this book in references to Chapter 9.

Chin, Austin B., Colby, Edwin S., and Robins, Edith G. *Physical and Mental Health.* Background paper for the 1971 White House Conference on Aging. Washington, D.C.: Administration on Aging, 1970.

Goldfarb, Alvin I. "Geriatric Psychiatry." In *A Comprehensive Textbook of Psychiatry.* A. Freedman and H.I. Kaplan, eds. Baltimore: Williams and Wilkins, 1967.

Riley, Matilda and Foner, Anne. *Aging and Society. Vol I: An Inventory of Research Findings.* New York: The Russell Sage Foundation, 1968.
Chapter 16 pulls together numerous studies of old age mental disorder and deviance.

U.S. Senate Special Committee on Aging. *Mental Health Care and the Elderly: Shortcomings in Public Policy.* Washington, D.C.: Senate Special Committee on Aging, 1971.
An important analysis of what government does, and does not do, for mentally ill older people.

Institutional Care

Barney, Jane Lockwood. *Patients in Michigan's Nursing Homes: Who Are They? How Are They? Why Are They There?* Ann Arbor: Institute of Gerontology, The University of Michigan-Wayne State University, 1974.

Chin, Austin B., Colby, Edwin S., and Robins, Edith G. *Physical and Mental Health.* Background paper for the 1971 White House Conference on Aging. Washington, D.C.:Administration on Aging, 1970.

Institute of Gerontology, The University of Michigan-Wayne State Unisity. *How to Choose a Nursing Home: A Shopping and Rating Guide.* Ann Arbor: Institute of Gerontology, 1974.
A booklet for the potential nursing home patient, and his family and friends.

Institute of Gerontology, The University of Michigan-Wayne State University. *Relocation Reports.* Ann Arbor: Institute of Gerontology, 1973.
Three reports from a study of the effects of involuntary relocation on an older institutionalized population.

Riley, Matilda and Foner, Anne. *Aging and Society. Vol I: An Inventory of Research Findings.* New York: The Russell Sage Foundation, 1968.
Chapter 25 covers studies and surveys of institutional care.

U.S. Senate Special Committee on Aging. *Barriers to Health Care for Older Americans.* Hearings before the Subcommittee on Health of the Elderly. Washington, D.C.: The Senate Special Committee on Aging, 1973.
Testimony in these hearings bears on alternatives to nursing home care, improvement of homes, rehabilitation of patients, safety standards, and nutrition in homes. See the Index of the 1973 *Developments in Aging* to locate relevant parts of these hearings.

U.S. Senate Special Committee on Aging. *Developments in Aging: 1973 and January-March: 1974.* Washington, D.C.: The Senate Special Committee on Aging, 1974.
Chapter 4 "Nursing Homes: Default on Standards" describes the struggle between Congress and the Department of HEW over tougher standards for nursing homes. The Index also locates the sections of other Committee reports and hearings relevant to institutional care.

U.S. Senate Special Committee on Aging. *Trends in Long-Term Care.* Hearings by the Subcommittee on Long-Term Care. Parts 1-22. January 20, 1969-October 11, 1973. Washington, D.C.: The Senate Special Committee on Aging.
The record of the subcommittee's hearings comprises a comprehensive study of institutional care. See the Index of the 1973 *Developments in Aging* to locate relevant testimony.

Nutrition

Howell, Sandra C. *Nutrition and Aging: A Monograph for Practitioners.* Washington, D.C.: Administration on Aging, 1969.

Todhunter, E. Neige. *Nutrition.* Background paper for the 1971 White House Conference on Aging. Washington, D.C.: Administration on Aging, 1970.

CHAPTER 12
TRANSPORTATION, HOUSING, EMPLOYMENT

Transportation

Revis, Joseph S. *Transportation.* Background paper for the 1971 White House Conference on Aging. Washington, D.C.: Administration on Aging, 1970.

U.S. Senate Special Committee on Aging. *Developments in Aging: 1973, and January-March: 1974.* Washington, D.C.: The Senate Special Committee on Aging, 1974.
Chapter 10 summarizes committee hearings on transportation problems of the elderly in early 1974 and contains recommendations for legislative and administrative change.

U.S. Senate Special Committee on Aging. *Older Americans and Transportation: A Crisis in Mobility.* Senate report No. 91-1520. Washington, D.C.: Government Printing Office, Dec. 1970.

U.S. Senate Special Committee on Aging. *Transportation and Aging: Selected Issues.* Washington, D.C.: Government Printing Office. (Stock No. 1762-0042.) 1970.
Proceedings of an interdisciplinary conference in 1970. Section II covers transportation planning, engineering, and pricing. Section III describes notable programs.

Housing

Robbins, Ira S. *Housing the Elderly.* Background paper for the 1971 White House Conference on Aging. Washington, D.C.: Administration on Aging.

Thornton, Allan F. "Dimensions of the Older Adult Market in the United States." Speech delivered at the International Symposium for Housing and Environmental Design for Older Adults. Dec. 12, 1973. Washington, D.C.
Documentation for an extensive need for specially-designed housing for older people.

U.S. Senate Special Committee on Aging. *Developments in Aging: 1973, and January-March: 1974.* Washington, D.C.: Government Printing Office, 1974.
Chapter 5 covers developments in housing programs and new legislation.

U.S. Senate Special Committee on Aging. *Housing for the Elderly: A Status Report.* A committee working paper. Washington, D.C.: Senate Special Committee on Aging. April, 1973.

Employment

Sobel, Irvin. *Employment.* Background paper for the 1971 White House Conference on Aging. Washington, D.C.: Administration on Aging, 1970.

U.S. Senate Special Committee on Aging. *Developments in Aging: 1973 and January-March: 1974.* Washington, D.C.: Senate Special Committee on Aging, 1974.
Chapter 8 discusses the age discrimination in employment law and other manpower legislation.

U.S. Senate Special Committee on Aging. *Improving the Age Discrimination Law.* A committee working paper. Washington, D.C.: Senate Special Committee on Aging. September, 1973.

CHAPTER 13
THE LAW AND THE OLDER PERSON

General Reference

Pierce, William J. *A Handbook of Model State Statutes.* Washington D.C.: The National Council of Senior Citizens, 1971.
Model legislation covering housing, consumer protection, discrimination, protective services, rate reductions, tax relief, and other legislative approaches to the problems of the elderly. Technical for the non-lawyer, but an important resource for those working on the details of legislative reform.

U.S. Senate Special Committee on Aging. *Legal Problems Affecting Older Americans.* Hearings in St. Louis, Mo., August 11, 1970. Washington, D.C.: U.S. Government Printing Office, 1971.
The testimony of eight major witnesses. The topics they discuss include incompetency, the problems of private attorneys, housing, and legislative reform.

U.S. Senate Special Committee on Aging. *Legal Problems Affecting Older Americans: A Working Paper.* Washington, D.C.: U.S. Government Printing Office 1970.
Lawyers write about major legal problems of the elderly, including difficulties in benefit programs, medical care, and housing.

Crime

Feeney, Floyd and Weir, Adrianne. *The Prevention and Control of Robbery: A Summary.* University of California at Davis: Center on Administration of Criminal Justice, Feb. 1974.
Includes statistics on older people's vulnerability to crime in Oakland, Calif.

Goldsmith, Jack and Thomas, Noel E. "Crimes Against the Elderly: A Continuing National Crisis." *Aging.* Nos. 236-237. pp. 10-13, June-July, 1974.
An up-to-date and useful summary of the old age crime problem, along with discussion of the steps to counteract it.

U.S. Department of Justice, Law Enforcement Assistance Administration. *Advance Report: Crime in the Nation's Five Largest Cities.* April, 1974.
Contains some figures about crimes against older people, and documents the magnitude of underreporting of crimes.

Incompetency

Alexander, George J. "Surrogate Management of the Property of the Aged." *Syracuse Law Review.* Vol. 21, No. 1. pp. 87-173, 1969.
A legal analysis of the management of property in behalf of elderly incompetents. Includes the results of the author's study of incompetency proceedings in Central New York State.

Alexander, George J. "The Aged and Property Management: A Study of Dehumanization." Appendix 2 in *Legal Problems Affecting Older Americans.* Hearings before the U.S. Senate Special Committee on Aging. St. Louis, Mo. August 11, 1970. Washington, D.C.: U.S. Government Printing Office, 1971.
A summary of the author's study, reported fully in the Law Review article.

Lehmann, Virginia. *Guardianship and Protective Services for Older People.* Washington, D.C.: The National Council on the Aging, 1963.
Chapter 2 covers incompetency, guardianship, power of attorney and related matters.

The National Council on the Aging. "The Law and the Impaired Older Person: Protection or Punishment?" Washington, D.C.: The Council, 1966.
Proceedings from a 1966 symposium on legal aspects of incompetency and commitment.

Involuntary Commitment

Braginsky, D.D. and Braginsky, B.M. "Psychologists: High Priests of the Middle Class." *Psychology Today* Vol. 7 No. 7. December, 1973.
Studies suggesting that diagnostic patterns betray a middle class bias among psychiatrists.

Friedman, Julian R. and Daly, Robert W. "Civil Commitment and the Doctrine of Balance: A Critical Analysis." *Santa Clara Lawyer*. Vol. 13. pp. 503-517. 1973.
A legal examination of commitment statutes.

Szaz, Thomas. *The Myth of Mental Illness*. New York: Harper, 1961.

Providing Legal Services

Fry, William R. "The Senior Citizen Paralegal: An Advocate for the Elderly Poor." *Aging*. Jan-Feb 1974. pp. 10-14.
A helpful article describing the use of non-lawyers to deliver legal services. Includes a bibliography of other publications and films about paralegals.

National Council of Senior Citizens. "Legal Needs of the Aging Poor: A Preliminary Survey." Washington, D.C.: Legal Research and Services for the Elderly Program of the NCSC, December, 1968.
A survey of the major legal problems of elderly poor.

Peters, Charles. "The Screwing of the Average Man: How Your Lawyer Does It." *The Washington Monthly*. Vol. 5, No. 12. pp. 33-42. February 1974.
Consumer complaints about high fees and other practices of the bar.

Stevens, Francis B. and Maxey, John L. "Representing the Unrepresented: A Decennial Report on Public-Interest Litigation in Mississippi." *Mississippi Law Journal*. Vol. 44. No. 3. 1973.
While it mentions older people only in passing, this historical and theoretical article shows what can happen when the unrepresented get lawyers.

Terris, Bruce J. *Legal Services for the Elderly*. Technical Assistance Monograph No. 9. Washington, D.C: The National Council on the Aging, February, 1972.
The best available summary of the legal needs of older people. Stresses services to poor elderly, and includes many imaginative proposals to deliver them more effectively.

APPENDIX

SOURCES OF INFORMATION

By Michele Christner
Institute of Gerontology

This appendix lists and describes some of the more useful sources of information in the field of aging. The first part describes the major public and private organizations which are active in programs for the elderly. The second part lists the journals, newsletters, reference sources, and other publications which are of particular value to professionals in the field. These organizations and publications can supply up-to-date information about a field characterized by diversity, innovation, and rapid change. This includes information about characteristics of the elderly, new studies in the field, development of innovative service and planning approaches, and new legislation affecting the elderly. The third and final part of the appendix is a selected bibliography on aging.

I
AGENCIES AND ORGANIZATIONS

UNITED STATES GOVERNMENT

The 1973 *Developments in Aging*, published by the U.S. Senate Special Committee on Aging, lists 25 departments and agencies of the U.S. Government with substantial responsibilities for programs affecting older Americans. The reader should consult the annual *Developments* for reports on the activities of these agencies. Here we mention several units of special importance.

THE SENATE SPECIAL COMMITTEE ON AGING
G-225 Senate Office Building
Washington, D.C. 20510
(202) 225-5364

Subcommittees:
- Housing for the Elderly
- Employment and Retirement Incomes
- Federal, State and Community Services
- Consumer Interests of the Elderly
- Health of the Elderly
- Long-Term Care
- Retirement and the Individual

The committee and its standing subcommittees publish a constant series of hearings, studies, and working papers throughout the year. An essential resource is *Developments in Aging*, an annual summary of federal action in the field of aging and a compendium of the committee's activities. *Developments* is published at the beginning of each year and covers the previous year. Hearings and reports are usually available free of charge from the committee. Interested parties should write and ask to be placed on the committee's mailing list.

ACTION
806 Connecticut Ave. NW
Washington, D.C. 20525
(202) 655-4000

ACTION is the federal agency responsible for coordinating volunteer programs involving older people, including Retired Senior Volunteer Program (RSVP), Service Corps of Retired Executives (SCORE), Foster Grandparents, and Green Thumb. An informative and helpful newsletter "InterAction" describes developments on a regular basis.

ADMINISTRATION ON AGING
Department of Health, Education, and Welfare
Office of Human Development
Washington, D.C. 20201
(202) 245-0724

The Administration on Aging administers programs under the Older Americans Act of 1965 and its subsequent amendments. These include Title VII nutrition programs, Title III aid to state and area agencies on aging, research and demonstration programs, and training grants. The magazine *Aging*, published by the AoA, is an essential resource. The AoA also regularly publishes a variety of booklets, pamphlets, and other publications bearing on programs and services for older people. Its National Clearinghouse on Aging provides data analysis and dissemination, public information, and technical assistance.

BUREAU OF THE CENSUS
Suitland, Md. 20233
(202) 655-4000

This office publishes the *Current Population Reports*, essential resources for those seeking data about older people in localities, states, and regions. The *Reports* include data about education levels, housing, income, employment, voting records, and marital status of older people. Special reports also concentrate on minority groups. Another source for this kind of data should be the state office on aging and local area agencies on aging. Many of the *Current Population Reports* should also be on file in local libraries, especially those connected with colleges and universities.

BUREAU OF LABOR STATISTICS
441 G St. NW
Washington, D.C. 20212
(202) 961-2221

Another source of demographic information. The BLS specializes in data about income, employment, and expenditure patterns.

SOCIAL SECURITY ADMINISTRATION
6401 Security Blvd.
Baltimore, Md. 21235

The Office of Research and Statistics publishes valuable reports about trends in the aging population of the United States. It publishes the *Social Security Bulletin* which also includes a comprehensive annual report on the Social Security program.

FEDERAL REGIONAL OFFICES

Much of the federal administration of programs for the aging is handled through 10 federal regional offices. Each has a regional staff for aging. These offices can also often supply data and program information more rapidly than central offices in Washington. The addresses of the regional offices, and the states they cover, are listed below.

Region 1: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont.

J.F. Kennedy Federal Building
Government Center
Boston, Mass. 02203

Region 2: New Jersey, New York, Puerto Rico, Virgin Islands.

26 Federal Plaza
New York, N.Y. 10007

Region 3: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia.

P.O. Box 12900
Philadelphia, Pa. 12900

Region 4: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee.

50 Seventh St. NE
Atlanta, Ga. 30323

Region 5: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin.

433 West Van Buren
New Post Office Building
Chicago, Ill. 60607

Region 6: Arkansas, Louisiana, New Mexico, Oklahoma, Texas.

1114 Commerce Street
Dallas, Texas 75202

Region 7: Iowa, Kansas, Missouri, Nebraska.

601 East 12th Street
Kansas City, Mo. 64106

Region 8: Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming.

19th and Stout Streets
Federal Office Building
Denver, Colo. 80202

Region 9: Arizona, California, Guam, Hawaii, Nevada, Samoa, Trust Territories.

Federal Office Building
50 Fulton Street
San Francisco, Calif. 94102

Region 10: Alaska, Idaho, Oregon, Washington.

Arcade Building
1319 2nd Ave.
Seattle, Washington 98101

PRIVATE ORGANIZATIONS

AMERICAN ASSOCIATION OF HOMES FOR THE AGING
529 14th St. NW
Washington, D.C. 20004
(202) 347-2000

Members of AAHA include voluntary non-profit and governmental homes for the aging, other interested individuals, and organizations. It exists to provide a unified means of identifying and solving common problems to protect and advance the interests of the residents served. The AAHA participates in a liaison with government in developing plans for training of administrators of homes, conducts institutes and workshops on current concerns, such as accreditation, financing, the meaning of institutional life, and planning for the residents of the future.

AAHA has several different publications and sponsors an annual convention.

AMERICAN ASSOCIATION OF RETIRED PERSONS - NATIONAL RETIRED TEACHERS ASSOCIATION
1909 K St. NW
Washington, D.C. 20006
(202) 872-4700

AARP-NRTA has a membership of 6,700,000 persons 55 years of age or older, whether or not retired. Their aim is to improve every aspect of living for older people. This organization has a library and several publications including *NRTA Journal* and *AARP Modern Maturity*. *AIM* (Action for Independent Maturity) is a division of *AARP* for persons 50 years of age. It has its own magazine *Dynamic Maturity* and offices at 1909 K Street, N.W., Washington, D.C. 20006.

AMERICAN NURSING HOME ASSOCIATION
1025 Connecticut Ave., NW
Suite 607
Washington, D.C. 20036
(202) 296-5636

A federation of state associations of nursing homes, this group includes profit and non-profit homes. It prepares an annual compilation of nursing home and bed totals and welfare payments by state. In addition to a 2000-volume library, the association has several publications.

AMERICAN PUBLIC WELFARE ASSOCIATION
1313 East 60th Street
Chicago, Ill. 60637

The American Public Welfare Association has prepared teaching materials, anticipating the spread of gerontological training through universities and professional schools. It has a special committee to improve relations between welfare departments and older people.

GERONTOLOGICAL SOCIETY
One Dupont Circle NW
Washington, D.C. 20036
(202) 659-4698

The Gerontological Society is a professional organization comprised of those interested in improving the well-being of older people by promoting scientific study of the aging process, publishing information about aging and bringing together all groups interested in older people.

The Society publishes the *Journal of Gerontology* ($26 per year) and *The*

Gerontologist ($12.50 per year). It also publishes "Selected Readings in Gerontology" irregularly. In addition to publications, the Society sponsors an annual convention/conference for all gerontologists and those interested in the field.

NATIONAL CENTER FOR VOLUNTARY ACTION
1625 Massachusetts Ave. NW
Washington, D.C. 20006
(202) 797-7800

The NCVA is a non-governmental, non-profit organization which promotes and supports volunteers and voluntary efforts. Its work includes assisting communities in development of Voluntary Action Centers; providing data on voluntary efforts everywhere through its clearing house; and sponsoring the Annual National Volunteer Awards. NCVA publishes a free newsletter as well as numerous program descriptions that are relevant to work in the field of aging.

NATIONAL COUNCIL OF SENIOR CITIZENS
1511 K Street NW
Washington, D.C. 20005
(202) 783-6850

The National Council of Senior Citizens is an organization of 3,000 autonomous senior citizens clubs, associations, councils, and other groups with a combined membership of over 3,000,000 persons. It is an educational and action group which supports Medicare; increased Social Security; improved recreational, educational, and health programs; increased voluntary service programs; reduced costs on drugs; better housing; and other programs to aid senior citizens. It sponsors mass rallies, educational workshops, leadership training institutes, provides speakers on Medicare or other programs concerning senior citizens; helps organize and develop programs for local and state groups. The NCSC encourages participation in social and political action activities. It does not endorse candidates for political office but works in behalf of issues. Distributes films, news materials, special reports and other materials. Maintains a library of books and a collection of materials on Medicare and other programs.

THE NATIONAL COUNCIL ON THE AGING
1828 L Street NW
Washington, D.C. 20036
(202) 223-6250

The NCOA is a voluntary agency that provides leadership services for organizations and individuals concerned with aid to the aging. It is non-governmental, non-profit and tax-exempt. It was organized in 1950 by community leaders, civic groups, government agencies and others who felt the need for professional advice and information in their field.

The National Council on the Aging sponsors the National Institute of Senior Centers (newsletter and bibliography available) and the National Institute on Industrial Gerontology, which publishes the journal, *Industrial Gerontologist*. A catalogue describing these publications and others available from the National Council is available and is an excellent resource.

COLLEGES AND UNIVERSITIES

Colleges and universities which are active in gerontology are excellent sources of information and training. The following is a partial listing of institutions of higher education which have units concerned with training, research, and service in the field of aging. All of the institutions listed are members of the Association for Gerontology in Higher Education. The president of the AGHE is Walter M. Beattie, All-University Gerontology Center, Syracuse University, Syracuse, New York 13210.

ALABAMA

Center for the Study of Aging
School of Social Work
The University of Alabama
P.O. Box 1935
University, Alabama 35486

CALIFORNIA

Human Development Program
University of California-San Francisco
1415-25 Fourth Avenue
San Francisco, Calif. 94122

Gerontology Center
University of Southern California
Los Angeles, Calif. 90007

DISTRICT OF COLUMBIA

Institute of Gerontology
Federal City College
1343 H Street NW, 12th Floor
Washington, D.C. 20005

FLORIDA

Florida State University
Tallahassee, Fla. 35306

Center for Gerontological Studies
University of Florida
221 Matherly Hall
Gainesville, Fla. 32601

Institute on Aging
University of South Florida
4204 Fowler Avenue
Tampa, Fla. 33620

GEORGIA

University of Georgia
Athens, Ga. 30601

HAWAII

School of Public Health
University of Hawaii
Honolulu, Hawaii 96822

ILLINOIS

Committee on Human Development
University of Chicago
5730 S. Woodlawn Ave.
Chicago, Ill. 60637

INDIANA

Ball State University
Muncie, Indiana 47306

MASSACHUSETTS

Boston University School of Medicine
15 Stoughton Street
Boston, Mass. 02118

Florence Heller Graduate School
Brandeis University
Waltham, Mass. 02154

MICHIGAN

Institute of Gerontology
Univ. of Mich. - Wayne State Univ.
543 Church Street
Ann Arbor, Mich. 48104

Institute of Gerontology
Univ. of Mich. - Wayne State Univ.
856 Mackenzie Hall
5050 Cass Avenue
Detroit, Mich. 48202

MINNESOTA

School of Public Affairs
314 Social Sciences Building
University of Minnesota
Minneapolis, Minnesota 55455

MISSOURI

Midwest Council for Social Research in Aging
Institute for Community Studies
2 West 40th Street
Kansas City, Mo. 66111

Institute of Applied Gerontology
Saint Louis University
3550 Lindell Blvd.
St. Louis, Mo. 63103

Department of Psychology
Washington University
St. Louis, Mo. 63130

NEBRASKA

School of Public Affairs & Community Service
The University of Nebraska at Omaha
Box 688, Downtown Station
Omaha, Nebraska 68101

NORTH CAROLINA

Duke University Medical Center
Center for the Study of Aging and Human Development
Durham, N.C. 27710

NEW HAMPSHIRE

New England Gerontology Center
New England Center for Continuing Education
Durham, New Hampshire 03824

NEW YORK

Teachers College
Columbia University
New York, N.Y. 10027

Hunter College
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College of Social and Behavioral Sciences
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Madison, Wisconsin 53705

II
JOURNALS AND OTHER PUBLICATIONS

PERIODICALS

Aging

Published by the Administration on Aging, Washington, D.C. 20201
$4.85 per year.

Aging is an excellent source of program descriptions, important legislative information, news from state and federal agencies, and reviews of publications in gerontology. It includes a calendar of upcoming conferences, workshops, and institutes.

Aging and Human Development

Quarterly published by Greenwood Press, Inc., Periodicals Division, 51 Riverside Avenue, Westport, Conn.
$20.00 per volume or $8.00 per single issue.

An academic journal concerned with psychological and social studies of aging, with special emphasis on research.

The Gerontologist

Published by Gerontological Society, One Dupont Circle NW, Washington, D.C. 20036
$12.50 per year, bi-monthly. Students: $10.00 for *Gerontologist* and *Journal of Gerontology*.

The Gerontologist is an excellent source for the most recent studies and research conducted in the field of aging. It is also a good source for information regarding training and education in the field. Its book reviews are a good way to keep abreast of the latest publications.

Journal of Gerontology

Published by Gerontological Society.
$26.00 per year; quarterly.

The *Journal* has a scientific research orientation and is basically divided into: biological and medical sciences; psychology and social sciences; and social gerontology. The *Journal* includes book reviews and a subject bibliography of current publications.

NEWSLETTERS

The Senior Citizens News

Published by National Council of Senior Citizens, 1511 K Street NW, Washington, D.C. 20005
Monthly at $2.50 per year.

Very good legislative coverage, national in scope.

Senate Special Committee on Aging Memorandum

Published by Senate Special Committee, G-2[illegible]5 Senate Office Building, Washington, D.C. 20510
Published several times a month - should be free.

Serves as a supplement to the hearings and studies of the committee. It has excellent legislative coverage, and describes the status of bills and new programs.

If you need other sources for determining the status of a particular bill, you may check the *Congressional Quarterly Weekly* magazine and/or the *National Journal*.

OTHER USEFUL TOOLS

Catalog of Federal Domestic Assistance

Available from the Government Printing Office at a cost of $7.50. Prepared annually by the Office of Management and Budget. The catalog is a comprehensive listing and description of federal programs and activities which provide assistance or benefits to Americans.

Resources For The Aging: An Action Handbook

Prepared for the Office of Economic Opportunity by the National Council on the Aging in 1969. This handbook was designed to assist communities and individuals to alleviate the needs of the aging poor through utilization of selected applicable federal programs, voluntary agencies, foundations and trusts. A new edition of this handbook will be published soon.

The Foundation Directory, 4th ed. New York: Columbia University Press, 1971.

This is an excellent source for determining possible outside sources of funding. The Directory describes each foundation in terms of size, personnel, and purpose.

U.S. Government Printing Office - Monthly Catalog

Published by the U.S. Government Printing Office, Washington, D.C. Monthly - $7.00 per year.

The monthly catalog lists all government publications including House and Senate Committee reports and hearings.

The Federal Register

Published daily, Tuesday through Saturday, by the Office of the Federal Register, National Archives and Records Service, General Services Administration, Washington, D.C. 20408

Subscription to the *Federal Register* is a $2.50 per month or $25.00 per year. A subscription can often be secured free of charge from your senator or representative.

The following kinds of documents are required to be filed and published in the *Federal Register:* 1) Presidential proclamations and executive orders of general interest and any other documents which the President submits or orders to be published. 2) Every document issued under proper authority, prescribing a penalty or a course of conduct, conferring a right, privilege, authority or immunity, or imposing an obligation relevant or applicable to the general public, the members of a class or the persons of a locality. 3) Documents or classes of documents required by Act of Congress to be filed and published. 4) Other documents deemed by the Director of the Federal Register to be of sufficient interest.

The *Federal Register* is very valuable for information regarding authority, rules and regulations governing federal programs.

U.S. Government Organization Manual

Available annually from the Government Printing Office.

The purpose of this publication is to keep its users abreast of the current organization, functions and major personnel of government agencies and of selected quasi-official agencies and international organizations. It explains how government agencies are set up and operated. By using the *Government Organization Manual*, one can understand the mechanics of the government, know the names of officials and the limitations and statutory authority of a government agency. The Manual prints a digest of complete statements already printed in the *Federal Register*. It sets forth for each agency its mode of creation and its authority, whether under statute, executive order or reorganization plan, and its organization, including major personnel, organization charts and functions.

Congressional Record

Proceedings of Congress are published in the *Congressional Record*, which is issued daily when Congress is in session. The Daily Digest of the Congressional Record, printed in the back of each issue of the *Record*, summarizes the proceedings of that day in each House, and before each of their committees and sub-committees, respectively. The Digest also presents the legislative program for each day and at the end of the week, gives the program for the following week.

III

A SELECTED BIBLIOGRAPHY IN AGING

The books in this bibliography were chosen because they fall into at least one of three categories: (1) Books which pull together a wide range of information within one volume, allowing the reader to obtain a working knowledge of an area relatively quickly. Most of these books also contain good bibliographies which identify other useful material. (2) Key books which cover areas of particular interest. Examples are books on economics, transportation, and mental health. (3) Books for the general reader which, because of style or presentation, reach a notable level of excellence.

BASIC BOOKS

The first group of books in this bibliography is probably the most important. These books can give the reader a basic grasp of the concepts, issues, and problems of aging. This is a brief summary of what these books contain. Rich and Gilmore's *Basic Concepts in Aging* is succinct, clear and brief. This is a good book to use to get someone started. *The Social Forces in Later Life* by Atchley covers much the same ground in greater depth. For further study, the reader should turn to the three landmark Handbooks: *The Handbook of Social Gerontology* by Tibbitts, the *Handbook of Aging and the Individual* by Birren, and *Aging in Western Societies* by Burgess. The two Riley and Foner volumes, *Aging and Society, Vols. I and II*, and the two-volume Oregon State *Perspectives in Aging*, provide more up-to-date summary data and analysis. Finally, Neugarten's *Middle Age and Aging* includes many excellent articles on specialized topics not explicitly covered elsewhere.

BASIC CONCEPTS OF AGING: A PROGRAMMED MANUAL. Thomas A. Rich and Alden S. Gilmore. Administration on Aging Publication No. 274. Washington, D.C.: U.S. Government Printing Office, 1969. 122 pp. $1.25

This is a small workbook designed for self-teaching. It employs the techniques of programmed instruction, where material is presented in a logical structured framework. The programmed manual can be the core of a rapid and useful overview of the basic concepts of aging.

THE SOCIAL FORCES IN LATER LIFE. Robert C. Atchley. Belmont, Calif.: Wadsworth, 1972. 341 pp.

A textbook designed for advanced undergraduates and graduate students in social gerontology. It is up-to-date, well-organized, comprehensive. This is one of the few textbooks in gerontology, and includes very useful bibliographies.

HANDBOOK OF SOCIAL GERONTOLOGY. Clark Tibbitts, ed. Chicago, Ill.: University of Chicago Press, 1960. 770 pp.

This book is the first and still the best one-volume survey of the social aspects of aging. Its 19 chapters are grouped into three major sections: the basis and theory of societal aging, the impact of aging on individual activities and social roles, and aging and the reorganization of society. The chapters cover such topics as economic security, retirement, leisure, family, religion, health, and governmental functions. The reader can use this book to obtain a rapid and solid knowledge of any particular area of social gerontology he is interested in.

HANDBOOK OF AGING AND THE INDIVIDUAL. James E. Birren, ed. Chicago, Ill.: University of Chicago Press, 1959. 939 pp.

An authoritative one-volume survey of the psychological and biological aspects of aging, still the best summary available. In 24 chapters, the authors discuss such topics as learning, intelligence, sensory processes, adjustment, psychopathology, physiological aging, and environmental factors. This book provides information which is essential for an understanding of the processes of individual aging. There is no better one-volume survey of this material.

AGING IN WESTERN SOCIETIES. Ernest W. Burgess, ed. Chicago, Ill.: University of Chicago Press, 1960. 494 pp.

A survey of the problems of older people and the solutions Western societies have adopted for them. Part I of the book summarizes the American and Western European action in 11 specific areas of concern, including health and mental health, housing, employment, income security, and family relationships. Part II consists of 14 case studies of outstanding European programs which have relevance to American social policy. While some of the particular programs are outdated, this book is a useful way for planners, policymakers, and students of gerontology to broaden their thinking about solutions to the problems facing older Americans.

AGING AND SOCIETY. VOL. I: AN INVENTORY OF RESEARCH FINDINGS. Matilda W. Riley and Anne Foner. 636 pp. VOL II: AGING AND THE PROFESSIONS. 410 pp. New York: Russell Sage Foundation. 1968.

Volume I of this remarkable work selects, condenses, and organizes social science findings about human beings in their middle and later years. It is essentially a reference work. Volume II draws upon Volume I and interprets the inventory for the professional worker who is concerned with older people. These professions include social work, medicine, nursing, public health, financial management, architecture and planning, the law, the ministry, education, and mass communication. This is an extremely valuable tool for introducing professionals to their responsibilities to older people.

PERSPECTIVES IN AGING. VOL. I: RESEARCH FOCUS. Frances G. Scott and Ruth M. Brewer, eds. 313 pp. VOL. II: OPERATIONAL FOCUS. Corvallis, Ore.: Oregon State University, 1971.

Volume I is a good summary of the status of gerontology as a scientific discipline. It covers the available knowledge in the major areas of gerontology, and proposes goals for research. While most of the papers are written by professionals for other professionals, the editors have wisely stressed "jargon-free" material. Volume II also surveys the field of gerontology, but replaces the research focus with a practical emphasis. It attempts to relate theory, research, and practice. A most valuable book for practioners, those who train them, and those who coordinate their efforts.

MIDDLE AGE AND AGING. Bernice L. Neugarten, ed. Chicago, Ill.: University of Chicago Press, 1968. 596 pp.

Some 58 papers on topics ranging from personality theory to sexual relationships. The major sections include theories of aging, family relationships, death and dying, age-sex roles, and health. This book is an ambitious and successful attempt to pull material together from disparate sources. Many of the articles are focused on quite specific topics, such as disenchantment in the later years of marriage, new careers in middle age, religiosity in old age, and family help patterns.

SELECTED TOPICS

ECONOMICS OF AGING: TOWARD A FULL SHARE IN ABUNDANCE. Hearings Before the U.S. Senate Special Committee on Aging, First Session, Ninety-Third Congress. Parts 1-8. Washington, D.C.: U.S. Government Printing Office, 1970. Index to Hearings and Reports, 1973.

More than 2000 pages of hearings and reports by the Senate Committee over a two-year period. It is the most thorough study of the economics of aging ever made. It includes working papers on economics of aging, employment, health economics, home ownership, pensions, social security, and retirement, which are among the best material available on these subjects.

TRANSPORTATION AND AGING: SELECTED ISSUES. Washington, D.C.: U.S. Government Printing Office. (Stock Number 1762-0042.) 208 pp.

This volume, based on proceedings of an Interdisciplinary Workshop on Transportation and Aging in 1970, gathers much of the relevant material on the topic. Section II covers transportation planning, engineering, and pricing; Section III describes notable programs which make transportation more accessible to the elderly.

RETIREMENT. Frances Carp, ed. New York: Behavioral Publications, 1972. 409 pp.

A collection of papers examining retirement from a multitude of angles, mixing academic and popular styles. Invaluable for planners, personnel directors, union officials, and others involved with retirement programs, and setting retirement policy.

PREPARATION FOR RETIREMENT. Woodrow W. Hunter. Ann Arbor: Institute of Gerontology, The University of Michigan-Wayne State University, 1973. 108 pp.

A text for use in pre-retirement preparation programs, the best around. Eleven short chapters in Part I discuss health, mental health, finances, legal affairs, and other retirement issues. Vignettes and short stories in Part II illustrate these issues and express the experience of retirement.

AGING AND MENTAL HEALTH. Robert N. Butler and Myrna I. Lewis. St. Louis: The C.V. Mosby Co., 1973. 306 pp. $5.95.

This book is a useful resource for practitioners who need to know about the psycho-social dynamics of aging. Written in a practical non-textbook style, this book attacks negative stereotypes, presents a positive view of aging, and covers both the functional and organic problems of age and the treatment of specific conditions.

ON DEATH AND DYING. Elisabeth Kübler-Ross. New York: Macmillan, 1969. 260 pp.

An excellent discussion of the humane treatment of the dying person. Of special value to medical personnel, nursing home administrators and staff, and the families of dying people.

FACTS AND FIGURES ON OLDER AMERICANS. Prepared by Herman E. Brotman. Numbers 1-10. Published by the Administration on Aging, 1971-1973.

These 10 small reports analyze the 1970 census data on older Americans, and are the most up-to-date demographic material available. They are also very easy to understand and use. They cover such topics as poverty, state trends and federal outlays in aging.

BOOKS FOR THE GENERAL READER

THE COMING OF AGE. Simone de Beauvoir. New York: G.P. Putnam Sons. 1972. 585 pp.

A masterpiece of analysis and synthesis by a renowned social critic. To expose the "shameful secret" of aging, de Beauvoir views aging through the prisms of literature, history, philosophy, and anthropology. Her vision of aging is gloomy; as a Marxist, she proposes that substantial improvement in the situation of older people will require a social revolution. Of particular value is her ambitious attempt to express what it feels like to be old.

LEARN TO GROW OLD. Paul Tournier. New York: Harper & Row. 1971. 248 pp. $4.95.

A Christian psychiatrist's personal exploration of aging. Warm and insightful. Tournier discusses both his vision of aging and its practical aspects.

NOBODY EVER DIED OF OLD AGE. Sharon Curtin. Boston: Little, Brown. 1972.

The best-selling account of a young journalist's encounters with older people. She loves and respects the old, and denounces the way they are usually treated in society.

CULTURE AND AGING. Margaret Clark and Barbara Anderson. Springfield, Ill.: Charles C. Thomas. 1967. 478 pp.

An outstanding anthropological study of a population of mentally ill and mentally healthy old people in the San Francisco Bay area. The book is notable for its highly readable style, its provocative case study materials, and the connections the authors make between the inner experience of aging and the way the social system responds to old people.

AGING IN AMERICA. Bert Kruger Smith. Boston: Beacon Press. 1973. 239 pp.

The author likes old people and takes a positive attitude toward aging. This book also contains a useful chapter summarizing a number of federal, state, and local programs aimed at the aging. The author also discusses steps the aging individual and his family can take to make a successful adjustment to old age.

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